



MEDICARE AND MEDICAID ISSUES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON

HEALTH AND THE ENVIRONMENT

COMMITTEE ON ENERGY AND COMMERCE

AND THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

ON

MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT
OF 1985—H.R. 1091, H.R. 1370, H.R. 1369

MARCH 19, 1985 (Joint with Ways and Means)

MEDICARE AND MEDICAID SUPPORT OF MEDICAL EDUCATION

APRIL 3, 1985

PHYSICIAN PAYMENT UNDER MEDICARE

APRIL 26, 1985

Serial No. 99-19

(COMMITTEE ON ENERGY AND COMMERCE)

Serial No. 99-20

(COMMITTEE ON WAYS AND MEANS)

Printed for the use of the Committee on Energy and Commerce, and Committee
on Ways and Means

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BEFORE THE



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MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1985—MEDICAL IMPOSTORS ACT OF 1985

TUESDAY, MARCH 19, 1985

HOUSE OF REPRESENTATIVES, COMMITTEE ON ENERGY AND COMMERCE, SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT; AND COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HEALTH,

Washington, DC.

The subcommittees met, pursuant to notice, at 1:05 p.m., in room 1100, Longworth House Office Building, Hon. Henry A. Waxman and Hon. Fortney H. (Pete) Stark (chairmen of the subcommittees) presiding.

Mr. STARK. The subcommittees will come to order.

Mr. Waxman, do you have an opening statement?

Mr. WAXMAN. Yes, I do. Thank you.

Our two subcommittees today are holding their second joint hearing on the Medicare and Medicaid Patient and Program Protection Act. We made a good deal of headway last fall with this bill, but were unable to complete our work before the Congress adjourned. I am hopeful that we will be able to move this bill expeditiously this spring.

H.R. 1370, and the other bills under consideration today, represent an important piece in an overall strategy to enhance the effectiveness and the integrity of the Medicare and Medicaid Programs. They are designed to provide safeguards for the beneficiaries of these programs so that they will receive health care meeting the highest standards of quality, as well as to make sure that program dollars are not wasted on inadequate or inappropriate care. If we make sure that all the money spent in these programs is spent effectively, perhaps we can blunt some of the continuing pressure from the administration to make cuts in these programs in order to reduce the deficit.

The main thrust of H.R. 1370 is to consolidate various existing fraud and abuse provisions in the Medicare and Medicaid Programs and fill in some identified shortcomings in those authorities. The most significant addition, which grows out of some helpful work by the GAO, would give the Secretary of Health and Human Services authority to bar a practitioner who had lost his license to practice in one State, from participating in the Medicare or Medicaid Program in any other State. A new provision has also been added that would authorize the termination of agreements with

prepaid health plans that fail to live up to their contractual obligations to provide the care needed by their enrollees.

Mr. Chairman, I appreciate the opportunity to join with your subcommittee in this joint hearing, and before we recognize some of our members who may have opening statements, you may want to recognize yours and have your members speak to the issues.

Mr. STARK. Thank you. I have an opening statement that I'd like to appear in the record. I'd like to welcome Chairman Waxman and the members of his subcommittee, and point out that we are holding joint hearings on the Medicare and Medicaid Patient and Program Protection Act of 1985 and the Medical Impostors Act of 1985.

[Mr. Stark's prepared statement follows:]

OPENING STATEMENT OF HON. FORTNEY H. (PETE) STARK

Today, the Health Subcommittee of Ways and Means, in conjunction with the Health and the Environment Subcommittee of the Energy and Commerce Committee is holding hearings on the Medicare and Medicaid Patient and Program Protection Act of 1985 and the Medical Impostors Act of 1985.

The Medicare and Medicaid Patient and Program Protection Act is designed to protect beneficiaries from physicians who have been disciplined in one State and quickly relocate to another State and easily obtain a medicare provider number. This bill would allow the Secretary of the Department of Health and Human Services to exclude such physicians from medicare nationwide and require States to exclude them from Medicaid and other State health programs. This bill would expand the Secretary's authority by giving her the ability to exclude health practitioners who have been convicted of patient neglect, unlawful distribution of a controlled substance or fraud.

This bill closes loopholes that have been allowed to exist for too long. Everyone's against fraud and abuse. This bill does something about it. The Government cannot afford to waste money on providers who mistreat their patients. And patients cannot afford to gamble with their lives when practitioners who've been convicted of improprieties are allowed to continue preying on the public.

Congressman Ron Wyden has introduced the Medical Impostors Act of 1985. This bill would impose a penalty on doctors who have obtained their licenses by misrepresenting a material fact, such as graduating from a medical school that they never attended. In addition, it would penalize doctors who falsely claim to be certified in a board specialty.

Protecting patients is the least we can do because they are in a weak position to begin with. These bills are long overdue. Our beneficiaries deserve the protection that these bills will provide.

Mr. STARK. This bill passed our committee last year, and closing the loopholes that have been allowed to exist is, I think, a worthy purpose.

Others have statements in support of that, and I want to mention that Congressman Ron Wyden has introduced the Medical Impostors Act of 1985, which would impose a penalty on doctors who have obtained their licenses by misrepresenting a material fact—such as graduating from a medical school that they never attended.

In addition, it would penalize doctors who falsely claim to be certified in a board specialty.

I think the overall summation is that protecting patients is the least we can do, because they are in a very weak position to begin with.

These bills are long overdue, and our beneficiaries deserve the protection these bills hopefully will provide.

At this point I'd like to recognize the ranking member of the House Ways and Means Subcommittee, Mr. Gradison.

Mr. GRADISON. Thank you, Chairman Stark, Chairman Waxman.

I am pleased that we are here today in an effort to expedite consideration and passage of important legislation which would protect Social Security Act beneficiaries from unfit health practitioners, as well as improve the antifraud abuse provisions of the act.

As you know, the legislation before us cuts across the jurisdictional responsibilities of our subcommittees. However, it is, I believe, relatively noncontroversial, and I would hope that we could move expeditiously to provide the added patient and program protections being proposed.

I particularly want to commend the efforts of my distinguished colleague Henson Moore for his leadership in pushing for this legislation.

I also commend the efforts of the distinguished Chairman on the Special Committee on Aging in the other body, Senator Heinz, for his leadership in calling for legislative action.

I am pleased to have joined with Chairman Stark and Chairman Waxman and my other distinguished House colleagues in cosponsoring H.R. 1370, and I look forward to hearing the testimony to be presented this afternoon.

Thank you, Mr. Chairman.

Mr. STARK. Mr. Waxman, do you have members who have opening statements?

Mr. WAXMAN. Yes. Mr. Wyden has an opening statement. I'd like to recognize him at this time.

Mr. WYDEN. Thank you very much, Mr. Chairman.

I, too, want to commend you and Chairman Stark for convening these hearings. I just have a couple of very brief remarks.

The Inspector General and the General Accounting Office have told us there are thousands of impostors across this country who pose as physicians. Many of these people purchased phony degrees. Some of them have never attended medical school. Some of them have attended foreign medical schools that have absolutely no pretense of quality. These frauds are actually seeing patients and are being reimbursed by the Federal Government in the process.

I have introduced legislation, H.R. 1091, the Medical Impostors Act, because right now while it is against the Medicare statutes for the beneficiaries to file for Medicare reimbursement under fraudulent pretenses, it is not against the Medicare laws for phony physicians to do the same. A phony doctor can perform physician services on an older person, file for Medicare reimbursement, and suffer no consequences under the Medicare laws.

My bill would even the score. It will make fraudulent doctors liable in the same way that fraudulent beneficiaries are under the Medicare laws.

One other point, Mr. Chairman. My bill would also provide penalties for physicians who claim to be a specialist in one area of medical practice when, in fact, they have no such certification.

I am concerned that older people are vulnerable to this type of fraud because physicians, even those who are licensed, shouldn't be allowed to bill themselves as specialists in a certain area unless they have really undergone the rigorous training and commitment that becoming certified involves.

I think this is important specifically now, at a time when we are facing hugely increasing medical malpractice costs. I think that my legislation to ensure that doctors are trained in the specialty that they hold themselves out for will help us to deal with that important area of holding down those costs.

I again want to thank Chairman Waxman and Chairman Stark for holding this hearing on my bill, as well as Henson Moore's bill.

[Mr. Wyden's opening statement follows:]

STATEMENT OF CONGRESSMAN RON WYDEN

HEARING ON THE MEDICAL IMPOSTORS ACT AND
THE MEDICARE PATIENT PROTECTION ACT

MARCH 19, 1985

Mr. Chairmen:

I really appreciate this hearing to discuss better ways to protect our Medicare and Medicaid patients from incompetent and fraudulent doctors.

I first want to commend my colleague, Mr. Moore, and both committees for putting together a bill that really will take us giant steps toward protecting our seniors and toward making sure that the dollars we're spending in health care are well-spent.

Under current law, the Secretary of Health and Human Services can refuse to allow providers to continue participating in the Medicare program if they have submitted false statements for payment, charged Medicare much more than their customary charges, or charged Medicare for many more services than a patient needed or services of low quality.

The Secretary also must suspend providers who have been convicted of criminal offenses related to their participation in the Medicare or Medicaid programs.

HR 1370 will strengthen current law by requiring the Secretary to suspend providers who have committed crimes under the Medicare and Medicaid provisions for 5 years. The bill also gives the Secretary discretion to exclude from participation in Medicare and Medicaid providers who are guilty of defrauding the federal health care programs, who are guilty of illegal drug distribution, who are incompetent, or who have lost their license in one state.

A very important part of this bill would require state licensing boards to notify the federal government of providers who lose their licenses.

I believe my bill, HR 1091, the Medical Impostors Act, will add to HR 1370 and will help make our laws even stronger to combat the problem of phony doctors.

Currently, while it is against the Medicare statutes for beneficiaries to file for Medicare reimbursement under fraudulent pretenses, it is not against the Medicare laws for phony physicians to do the same. A phony doctor can perform physician's services on a senior citizen, file for Medicare reimbursement, and suffer no consequences under the Medicare statutes. My bill would even the score -- it will make fraudulent doctors liable in the same way that fraudulent beneficiaries are.

My bill will also provide penalties for physicians who claim to be a specialist in one area of medical practice when in fact they have no such certification. I am very concerned that our seniors are especially vulnerable to this type of fraud. Physicians, even licensed ones, should not be allowed to bill themselves as specialists in a certain area unless they really have undergone the rigorous training and commitment that becoming certified involves. Especially in these days when we are facing a medical malpractice crisis, I think we should take firm steps to ensure that this unsavory practice doesn't continue.

Under my bill, a fraudulent provider could be subject to a civil monetary penalty of \$2,000 for each item or service charged to the Medicare/Medicaid programs and penalized twice the amount of each claim. Fraudulent providers are also subject to a fine of \$25,000 or a jail term of 5 years, or both. I understand that the part of the Social Security Act where this fine is determined has recently been amended to raise the fine to \$250,000.

I think there's a desperate need for this legislation, Mr. Chairmen. According to the testimony heard from the Inspector General and the General Accounting Office in last year's Aging Committee hearing on this problem, there are thousands of impostors across the country posing as physicians. Many of these people purchased phony degrees, some of them never even attended medical school, and some of them attended foreign medical schools that have no pretense of quality. These frauds are actually seeing patients and are being reimbursed by the federal government in the process.

In my home state of Oregon, there was a veritable "medical degree mill" operating where one man was arrested for fabricating medical and legal degrees for 2500 people in two years. He was also charged with selling fraudulent certificates of medical board membership.

What's particularly grotesque about all this is that at a time when critically needed government health care programs are being reduced, the federal government is spending precious tax dollars to support consumer fraud. Through Medicare reimbursement, and in other ways, charlatans are systematically fleecing the federal government.

Our taxpayers are spending over \$70 billion every year on Medicare, and some of these dollars are going to phony doctors. I hope, in the course of these hearings, that we can look for ways to increase consumers' awareness of which physicians are bogus and which have lost their licenses to practice. It's important that patients are able to protect themselves from these charlatans.

In these tight budget days, when the Administration is looking for ways to reduce spending on Medicare, we need to be sure that we're getting the best, most efficient service for our tax dollars.

I applaud the good work that has gone into my colleague's bill and I hope together these bills can move us forward to get charlatans out of our hospitals and away from our patients' bedsides. We owe it to the taxpayers and to unsuspecting Medicare/Medicaid patients to take action to curb these abuses.

Mr. STARK. Thank you very much.

If there are no other opening statements, Senator Heinz has asked if he could appear as his schedule would permit, and without objection we will give the Senator an opportunity to testify when he arrives at the hearing room.

Our first panel is Mr. Zimmerman, the Associate Director of Human Resources Division, and Mr. Kusserow, the Inspector General.

We drew straws, and it was agreed between Chairman Waxman and myself that I would be the bad guy. In the interest of time, each witness' prepared testimony—for which we want to extend our thanks for having them here in a timely fashion—will appear in the record in its entirety, but we are going to limit the witnesses in a rather crude fashion with those stop-and-go lights that will come flashing in your face, as we will limit members of the committee, to 5 minutes.

So we will ask that you summarize your testimony or position, and we will hold the members to the same restriction, in an effort to give everybody a chance to complete the hearings this afternoon as early as possible.

And with that admonition, I want to welcome Mr. Zimmerman and Mr. Kusserow, and you might like to identify the gentlemen with you. You may proceed to summarize your testimony in any manner you choose, or in whichever order.

In the absence of any other decision, we will call Mr. Zimmerman first.

[Testimony resumes on p. 45.]

[The text of H.R. 1370, H.R. 1091, and H.R. 1369 follow:]

99TH CONGRESS
1ST SESSION

H. R. 1370

To amend the Social Security Act to protect beneficiaries under the health care programs of that Act from unfit health care practitioners, and otherwise to improve the antifraud provisions of that Act.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 28, 1985

Mr. MOORE (for himself, Mr. WAXMAN, Mr. STARK, Mr. GRADISON, Mr. RANGEL, Mr. PEPPER, Mr. GEPHARDT, and Mr. WYDEN) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

A BILL

To amend the Social Security Act to protect beneficiaries under the health care programs of that Act from unfit health care practitioners, and otherwise to improve the antifraud provisions of that Act.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; REFERENCES IN ACT.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Medicare and Medicaid Patient and Program Protection Act
6 of 1985”.

(b) AMENDMENTS TO THE SOCIAL SECURITY ACT.—

Whenever in this Act an amendment is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

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Sec. 6. Obligation of health care practitioners and providers.

Sec. 7. Exclusion under the medicaid program.

Sec. 8. Miscellaneous and conforming amendments.

Sec. 9. Effective dates.

SEC. 2. EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128 (42 U.S.C. 1320a-7) is amended to read as follows:

“EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

“SEC. 1128. (a) MANDATORY EXCLUSION.—The Secretary shall exclude from participation in the programs under title XVIII any individual or entity that has been convicted of a criminal offense related to such individual’s or entity’s participation in the delivery of items or services under title XVIII or under any State health care program (as defined in subsection (g)).

1 “(b) PERMISSIVE EXCLUSION.—The Secretary may ex-
2 clude from participation in the programs under title XVIII
3 the following individuals and entities:

4 “(1) CONVICTION RELATING TO FRAUD OR PA-
5 TIENT ABUSE.—Any individual or entity that has been
6 convicted, under Federal or State law, in connection
7 with the delivery of health care items or services or
8 with respect to any act or omission in a program oper-
9 ated by or financed in whole or in part by any Federal,
10 State, or local government agency, of a criminal of-
11 fense relating to—

12 “(A) fraud, theft, embezzlement, breach of fi-
13 duciary responsibility, or financial abuse, or

14 “(B) neglect or abuse of patients.

15 “(2) CONVICTION RELATING TO OBSTRUCTION
16 OF AN INVESTIGATION.—Any individual or entity that
17 has been convicted, under Federal or State law, in
18 connection with the interference or obstruction of any
19 investigation into any criminal offense described in
20 paragraph (1) or subsection (a).

21 “(3) CONVICTION RELATING TO CONTROLLED
22 SUBSTANCE.—Any individual or entity that has been
23 convicted, under Federal or State law, of unlawful
24 manufacture, distribution, prescription, or dispensing of

1 a controlled substance or other criminal offense relating
2 to a controlled substance.

3 “(4) LICENSE REVOCATION OR SUSPENSION.—

4 Any individual or entity—

5 “(A) whose license to provide health care
6 has been revoked or suspended by a State licens-
7 ing authority or who otherwise lost such a license
8 for reasons bearing on the individual’s or entity’s
9 professional competence, professional conduct, or
10 financial integrity, or

11 “(B) who surrendered such a license while a
12 formal disciplinary proceeding was pending before
13 such an authority and the proceeding concerned
14 the individual’s or entity’s professional compe-
15 tence, professional conduct, or financial integrity.

16 “(5) SUSPENSION FROM FEDERAL HEALTH CARE
17 PROGRAM.—Any individual or entity which has been
18 suspended or excluded from participation, or otherwise
19 sanctioned, under any Federal program, including pro-
20 grams of the Department of Defense or the Veterans’
21 Administration, involving the provision of health care,
22 or under a State health care program (as defined in
23 subsection (g)).

24 “(6) SUBMISSION OF FALSE CLAIMS.—Any indi-
25 vidual or entity that the Secretary determines—

1 “(A) has knowingly and willfully made, or
2 caused to be made, any false statement or repre-
3 sentation of a material fact for use in an applica-
4 tion for payment under title XVIII or a State
5 health care program or for use in determining the
6 right to a payment under such title or program;

7 “(B) has submitted or caused to be submitted
8 bills or requests for payment under title XVIII or
9 a State health care program containing charges
10 (or, in applicable cases, requests for payment of
11 costs) for items or services furnished substantially
12 in excess of such individual's or entity's custom-
13 ary charges (or, in applicable cases, substantially
14 in excess of such individual's or entity's costs) for
15 such items or services, unless the Secretary finds
16 there is good cause for such bills or requests con-
17 taining such charges or costs;

18 “(C) has furnished items or services to pa-
19 tients (whether or not eligible for benefits under
20 title XVIII or a State health care program) sub-
21 stantially in excess of the needs of such patients
22 or of a quality which fails to meet professionally
23 recognized standards of health care;

24 “(D) is—

1 “(i) a health maintenance organization
2 (as defined in section 1903(m)) providing
3 items and services under a State plan ap-
4 proved under title XIX or

5 “(ii) an entity furnishing services under
6 a waiver approved under section 1915(b)(1),
7 and has failed in a substantial number of cases to
8 provide medically necessary items and services
9 that are required under law or the contract with
10 the State under that title; or

11 “(E) is an entity providing items and services
12 as an eligible organization under a contract under
13 section 1876 and has failed in a substantial
14 number of cases to provide medically necessary
15 items and services that are required under law or
16 such contract.

17 “(7) FRAUD, KICKBACKS, AND OTHER PROHIBIT-
18 ED ACTIVITIES.—Any individual or entity that the
19 Secretary determines has committed an act which is
20 described in section 1128B.

21 “(8) EXCLUSION OF ENTITIES.—Any entity with
22 respect to which the Secretary determines that a
23 person—

24 “(A)(i) with an ownership or control interest
25 (as defined in section 1124(a)(3)) in that entity or

1 “(ii) who is an officer, director, agent, or
2 managing employee (as defined in section 1126(b))
3 of that entity—

4 is a person—

5 “(B)(i) who has been convicted of any offense
6 described in subsection (a) or in paragraph (1), (2),
7 or (3) of this subsection;

8 “(ii) against whom a civil monetary penalty
9 has been assessed under section 1128A; or

10 “(iii) who has been excluded from participa-
11 tion under a program under title XVIII or under
12 a State health care program.

13 “(9) FAILURE TO DISCLOSE REQUIRED INFORMA-
14 TION.—Any entity that did not fully and accurately
15 make any disclosure required of it by section 1124 or
16 section 1126.

17 “(10) FAILURE TO SUPPLY REQUESTED INFOR-
18 MATION.—Any disclosing entity (as defined in section
19 1124(a)(2)) that fails to supply (within such period as
20 may be specified by the Secretary in regulations) upon
21 request specifically addressed to such entity by the
22 Secretary—

23 “(A) full and complete information as to the
24 ownership of a subcontractor (as defined by the
25 Secretary in regulations) with whom such entity

1 has had, during the previous 12 months, business
2 transactions in an aggregate amount in excess of
3 \$25,000, or

4 “(B) full and complete information as to any
5 significant business transactions (as defined by the
6 Secretary in regulations), occurring during the
7 five-year period ending on the date of such re-
8 quest, between such entity and any wholly owned
9 supplier or between such entity and any subcon-
10 tractor.

11 “(11) FAILURE TO SUPPLY PAYMENT INFORMA-
12 TION.—Any individual or entity furnishing items or
13 services for which payment may be made under title
14 XVIII or a State health care program that fails to pro-
15 vide such information as the Secretary finds necessary
16 to determine whether such payments are or were due
17 and the amounts thereof, or has refused to permit such
18 examination of its records by or on behalf of the Secre-
19 tary as may be necessary to verify such information.

20 “(12) FAILURE TO PROVIDE IMMEDIATE ACCESS
21 TO NECESSARY INFORMATION.—Any individual or
22 entity that fails to grant immediate access, upon rea-
23 sonable request (as defined by the Secretary in regula-
24 tions), to any of the following:

1 “(A) To the Secretary, or to the agency used
2 by the Secretary, for the purpose specified in the
3 first sentence of section 1864(a) (relating to com-
4 pliance with conditions of participation or pay-
5 ment).

6 “(B) To the Secretary or the State agency in
7 order to perform the reviews and surveys required
8 under State plans under paragraphs (26), (31),
9 and (33) of section 1902(a) and under section
10 1903(g).

11 “(C) To the Inspector General of the De-
12 partment of Health and Human Services for the
13 purpose of review of records, documents, and
14 other data necessary to the performance of the
15 statutory functions of the Inspector General.

16 “(D) To a State medicaid fraud control unit
17 (as defined in section 1903(q)) for the purpose of
18 conducting activities described in that section.

19 “(c) NOTICE OF EXCLUSION.—(1) An exclusion under
20 this section or under section 1128A shall only be effective at
21 such time and upon such reasonable notice to the public and
22 to the individual or entity excluded as may be specified in
23 regulations consistent with paragraph (2).

24 “(2) Such an exclusion shall be effective with respect to
25 services furnished to an individual on or after the effective

1 date of the exclusion; except that such exclusion shall not
2 apply to payments made under title XVIII or under a State
3 health care program for—

4 “(A) inpatient institutional services furnished to
5 an individual who was admitted to such institution
6 before the date of the exclusion, or

7 “(B) home health services and hospice care fur-
8 nished to an individual under a plan of care established
9 before the date of the exclusion,

10 until the passage of 30 days after the effective date of the
11 exclusion.

12 “(d) HEARING AND JUDICIAL REVIEW ON EXCLU-
13 SIONS UNDER THIS SECTION.—Any individual or entity that
14 is excluded from participation under this section is entitled to
15 reasonable notice and opportunity for a hearing thereon by
16 the Secretary to the same extent as is provided in section
17 205(b), and to judicial review of the Secretary’s final decision
18 after such hearing as is provided in section 205(g).

19 “(e) NOTICE TO STATES AND EXCLUSION UNDER
20 STATE HEALTH CARE PROGRAMS.—(1) The Secretary
21 shall promptly notify each appropriate State agency adminis-
22 tering or supervising the administration of each State health
23 care program of the fact and circumstances of each exclusion
24 effected under this section or section 1128A.

1 “(2) Each State health care program shall provide for
2 the exclusion from participation in that program of each indi-
3 vidual and entity during any period in which the individual or
4 entity is excluded from participation in the programs under
5 title XVIII pursuant to this section or section 1128A, except
6 that the Secretary may waive such required exclusion with
7 respect to an individual or entity if the Secretary receives
8 and approves a request for such waiver with respect to the
9 individual or entity from the State agency administering or
10 supervising the administration of the program.

11 “(3) The Secretary shall—

12 “(A) promptly notify the appropriate State or
13 local agency or authority having responsibility for the
14 licensing or certification of an individual or entity ex-
15 cluded from participation under this section or section
16 1128A of the fact and circumstances of such exclusion,

17 “(B) request that appropriate investigations be
18 made and sanctions invoked in accordance with appli-
19 cable State law and policy, and

20 “(C) request that such State or local agency or
21 authority keep the Secretary and the Inspector Gener-
22 al in the Department of Health and Human Services
23 fully and currently informed with respect to any ac-
24 tions taken in response to such request.

1 “(f) **PERIOD OF EXCLUSION.**—(1)(A) Except in the case
2 of an exclusion effected under subsection (b)(12), the notice of
3 exclusion under subsection (c) and the written notice under
4 section 1128A shall state the earliest date (which, in the case
5 of an exclusion effected pursuant to subsection (a), may not
6 be less than five years after the date of the exclusion) on
7 which the individual or entity may be reinstated under this
8 subsection.

9 “(B) In the case of an exclusion effected under subsec-
10 tion (b)(12), the notice of exclusion under subsection (c) shall
11 state the period of the exclusion, which shall be equal to the
12 sum of—

13 “(i) the length of the period in which the individ-
14 ual or entity failed to grant immediate access described
15 in subsection (b)(12), and

16 “(ii) an additional period, not to exceed 90 days,
17 set by the Secretary.

18 “(2) An individual or entity excluded from participation
19 under this section (other than under subsection (b)(12)) or
20 section 1128A may apply to the Secretary, in the manner
21 specified by the Secretary in regulations and at the end of the
22 initial period of exclusion and at such other times as the Sec-
23 retary may provide, for reinstatement as a participant in the
24 programs under title XVIII and under State health care
25 programs.

1 “(3) The Secretary shall provide for such reinstatement
2 if the Secretary determines, on the basis of the conduct of the
3 applicant which occurred after the date of the notice of exclu-
4 sion or which was unknown to the Secretary at the time of
5 the exclusion, that—

6 “(A) there is no basis under subsection (a) or (b)
7 or section 1128A(a) for a continuation of the exclusion,
8 and

9 “(B) there are reasonable assurances that the
10 types of actions which formed the basis for the original
11 exclusion have not recurred and will not recur.

12 “(4) The Secretary shall promptly notify each appropri-
13 ate State agency administering or supervising the administra-
14 tion of each State health care program of the fact and cir-
15 cumstances of each reinstatement made under this subsec-
16 tion.

17 “(g) DEFINITION OF STATE HEALTH CARE PRO-
18 GRAM.—For purposes of this section and sections 1128A and
19 1128B, the term ‘State health care program’ means—

20 “(1) a State plan approved under title XIX,

21 “(2) any program receiving funds under title V or
22 from an allotment to a State under such title, or

23 “(3) any program receiving funds under title XX
24 or from an allotment to a State under such title.”.

1 SEC. 3. CIVIL MONETARY PENALTIES.

2 (a) GROUNDS FOR IMPOSITION.—(1) Subsection (a)(1)
3 of section 1128A (42 U.S.C. 1320a-7a) is amended—

4 (A) by striking out “is for a medical or other item
5 or service” in the matter before subparagraph (A),

6 (B) by inserting “is for a medical or other item or
7 service” in subparagraph (A) after “(A)”,

8 (C) by striking out “or” at the end of subpara-
9 graph (A),

10 (D) by striking out “(B)” in subparagraph (B) and
11 inserting in lieu thereof “(C) is for a medical or other
12 item or services”,

13 (E) in subparagraph (C) (as so redesignated), by
14 striking out “section 1128” and all that follows
15 through “proceedings;” and inserting in lieu thereof
16 “this section or sections 1128, 1156, 1160(b) (as in
17 effect on September 2, 1982), 1862(d) (as in effect on
18 the date of the enactment of the Medicare and Medic-
19 aid Patient and Program Protection Act of 1985), or
20 1866(b);”, and

21 (F) by inserting after subparagraph (A) the follow-
22 ing new subparagraph:

23 “(B) the person knows or has reason to
24 know is false or fraudulent, or”, and

1 (2) Subsection (a)(2)(B) of such section is amended by
2 inserting “(or other requirement of a State plan under title
3 XIX)” after “State agency”.

4 (3) Subsection (a) of such section is further amended by
5 adding at the end thereof the following new sentence: “In
6 addition the Secretary may make a determination in the same
7 proceeding to exclude the person from participation in the
8 programs under title XVIII and in any State health care
9 program.”.

10 (4) No civil penalty or assessment may be imposed
11 under section 1128A(a) of the Social Security Act in the case
12 of a claim filed before August 13, 1981, if liability for the
13 amount of the penalty or assessment could not have been
14 imposed with respect to the claim under section 3729 of title
15 31, United States Code (relating to false claims).

16 (b) STATUTE OF LIMITATION ON ACTIONS.—Subsec-
17 tion (b)(1) of such section is amended by adding at the end
18 the following new sentences: “The Secretary may not initiate
19 an action under this section with respect to any claim later
20 than six years after the date the claim was presented. The
21 Secretary may initiate an action under this section by person-
22 al service or by mailing by registered or certified mail the
23 notice required by paragraph (2).”.

24 (c) CONFORMING AMENDMENT.—Subsections (b), (c),
25 (f), and (g) of such section are each amended by striking out

1 “penalty or assessment” and inserting in lieu thereof “penal-
2 ty, assessment, or exclusion” each place it appears.

3 (d) PRO-RATED PAYMENT OF RECOVERIES TO STATE
4 AGENCIES.—Subsection (e)(1)(A) of such section is amended
5 by striking out “equal to the State’s share of the amount paid
6 by the State agency” and inserting in lieu thereof “bearing
7 the same proportion to the total amount recovered as the
8 State’s share of the amount paid by the State agency for such
9 claim bears to the total amount paid”.

10 (e) NOTICE TO STATE AGENCIES.—Subsection (g) of
11 such section is further amended by inserting “the appropriate
12 State agency or agencies administering or supervising the ad-
13 ministration of State health care programs (as defined in sec-
14 tion 1128(g)),” after “professional organization,”.

15 (f) APPLICATION OF SUBPOENA POWER AND INJUNC-
16 TIVE POWERS.—Such section is further amended by adding
17 at the end the following new subsections:

18 “(i) The provisions of subsections (d) and (e) of section
19 205 shall apply with respect to this section to the same
20 extent as they are applicable with respect to title II.

21 “(j) Whenever the Secretary has reason to believe that
22 any person has engaged, is engaging, or is about to engage in
23 any activity which makes the person subject to a civil mone-
24 tary penalty under this section, the Secretary may bring an
25 action in an appropriate district court of the United States

1 (or, if applicable, a United States court of any territory) to
 2 enjoin such activity, or to enjoin the person from concealing,
 3 removing, or encumbering assets which may be required in
 4 order to pay a civil monetary penalty if any such penalty
 5 were to be imposed or to seek other appropriate relief.”.

6 **SEC. 4. CRIMINAL PENALTIES FOR ACTS INVOLVING MEDI-**
 7 **CARE AND STATE HEALTH CARE PROGRAMS.**

8 (a) **TECHNICAL AMENDMENTS.**—Section 1909 is
 9 amended—

10 (1) by amending the heading to read as follows:

11 “**CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE**
 12 **OR STATE HEALTH CARE PROGRAMS**”;

13 (2) in subsection (a)(1), by striking out “a State
 14 plan approved under this title” and inserting in lieu
 15 thereof “a program under title XVIII or a State health
 16 care program (as defined in section 1128(g))”;

17 (3) in the matter in subsection (a) following para-
 18 graph (4), by striking out “this title” the first place it
 19 appears and inserting in lieu thereof “the program”;

20 (4) in the last sentence of subsection (a), by strik-
 21 ing out “this title” the first place it appears and insert-
 22 ing in lieu thereof “title XIX”, and by striking out
 23 “this title” the second place it appears and inserting in
 24 lieu thereof “that title”;

25 (5) in paragraphs (1)(A), (1)(B), (2)(A), (2)(B), and
 26 (3)(A) of subsection (b), by striking out “this title” and

1 inserting in lieu thereof "title XVIII or a State health
2 care program" each place it appears;

3 (6) in subsection (c), by striking out "or home
4 health agency (as those terms are employed in this
5 title)" and inserting in lieu thereof "home health
6 agency, or other entity for which certification is re-
7 quired under title XVIII or a State health care pro-
8 gram"; and

9 (7) in subsection (d), by striking out "this title"
10 and inserting in lieu thereof "title XIX" each place it
11 appears.

12 (b) REDESIGNATION OF SECTION 1877(d) AS SECTION
13 1128B(e).—Subsection (d) of section 1877 is redesignated as
14 subsection (e) and is transferred and inserted in section 1909
15 at the end thereof.

16 (c) REDESIGNATION OF SECTION 1909 AS SECTION
17 1128B.—Section 1909, as amended by subsections (a) and
18 (b) of this section, is redesignated as section 1128B and is
19 transferred to title XI and inserted immediately after section
20 1128A.

21 (d) REPEAL.—Section 1877 (other than subsection (d)
22 thereof which was transferred under subsection (b) of this
23 section) is repealed.

1 SEC. 5. INFORMATION CONCERNING SANCTIONS TAKEN BY
2 STATE LICENSING AUTHORITIES AGAINST
3 HEALTH CARE PRACTITIONERS AND PROVID-
4 ERS.

5 (a) MEDICAID PLAN REQUIREMENT.—Section 1902(a)
6 of the Social Security Act is amended—

7 (1) by striking out “and” at the end of paragraph
8 (45),

9 (2) by striking out the period at the end of para-
10 graph (46) and inserting in lieu thereof “; and”, and

11 (3) by inserting after paragraph (46) the following
12 new paragraph:

13 “(47) provide that the State will provide informa-
14 tion and access to certain information respecting sanc-
15 tions taken against health care practitioners and pro-
16 viders by State licensing authorities in accordance with
17 section 1919.”.

18 (b) INFORMATION REQUIRED.—Title XIX is amended
19 by adding at the end the following new section:

20 “INFORMATION CONCERNING SANCTIONS TAKEN BY STATE
21 LICENSING AUTHORITIES AGAINST HEALTH CARE
22 PRACTITIONERS AND PROVIDERS

23 “SEC. 1919. (a) INFORMATION REPORTING REQUIRE-
24 MENT.—The requirement referred to in section 1902(a)(47) is
25 that the State must provide for the following:

1 “(1) INFORMATION REPORTING SYSTEM.—The
2 State must have in effect a system of reporting the fol-
3 lowing information with respect to formal proceedings
4 (as defined by the Secretary in regulations) concluded
5 against a health care practitioner or entity by any au-
6 thority of the State (or of a political subdivision there-
7 of) responsible for the licensing of health care practi-
8 tioners or entities:

9 “(A) Any adverse action taken by such li-
10 censing authority as a result of the proceeding, in-
11 cluding any revocation or suspension of a license
12 (and the length of any such suspension), reprimand,
13 censure, or probation.

14 “(B) Any dismissal or closure of the proceed-
15 ings by reason of the practitioner or entity surren-
16 dering the license or leaving the State or jurisdic-
17 tion.

18 “(C) Any other loss of the license of the
19 practitioner or entity, whether by operation of
20 law, voluntary surrender, or otherwise.

21 “(2) ACCESS TO DOCUMENTS.—The State must
22 provide the Secretary (or an entity designated by the
23 Secretary) with access to such documents of the au-
24 thority described in paragraph (1) as may be necessary
25 for the Secretary to determine the facts and circum-

1 stances concerning the actions and determinations de-
2 scribed in such paragraph for the purpose of carrying
3 out this Act.

4 “(b) FORM OF INFORMATION.—The information de-
5 scribed in subsection (a)(1) shall be provided to the Secretary
6 (or, under suitable arrangements made by the Secretary, to
7 another entity) in such a form and manner as the Secretary
8 determines to be appropriate in order to provide for activities
9 of the Secretary under this Act and in order to provide, di-
10 rectly or through suitable arrangements made by the Secre-
11 tary, information—

12 “(1) to licensing authorities described in subsec-
13 tion (a)(1),

14 “(2) to State agencies administering or supervis-
15 ing the administration of State health care programs
16 (as defined in section 1128(g)),

17 “(3) to utilization and quality control peer review
18 organizations described in part B of title XI, and

19 “(4) to State medicaid fraud control units (as de-
20 fined in section 1903(q)),

21 in order for such authorities to determine the fitness of indi-
22 viduals to provide health care services, to protect the health
23 and safety of individuals receiving health care through such
24 programs, and to protect the fiscal integrity of such pro-
25 grams.

1 “(c) CONFIDENTIALITY OF INFORMATION PROVID-
2 ED.—The Secretary shall provide for suitable safeguards for
3 the confidentiality of such of the information furnished under
4 subsection (a) as is not otherwise available to the public.”.

5 SEC. 6. OBLIGATION OF HEALTH CARE PRACTITIONERS AND
6 PROVIDERS.

7 Section 1156 (42 U.S.C. 1320c-5) is amended—

8 (1) by striking out “title XVIII” and “such title”
9 in subsection (a) and inserting in lieu thereof “this
10 Act” in each instance, and

11 (2) by striking out “title XVIII” each place it ap-
12 pears in subsection (b) and inserting in lieu thereof
13 “this Act”.

14 SEC. 7. EXCLUSION UNDER THE MEDICAID PROGRAM.

15 Section 1902 (42 U.S.C. 1396b) is amended by insert-
16 ing after subsection (f) the following new subsection:

17 “(g)(1) In addition to any other authority provided under
18 State law, a State may exclude any individual or entity from
19 participation in the State plan under this title for any reason
20 for which the Secretary could exclude the individual or entity
21 from participation in the programs under title XVIII under
22 section 1128 or 1128A.

23 “(2) In order for a State to receive payments for medi-
24 cal assistance under section 1903(a), with respect to pay-
25 ments the State makes to a health maintenance organizations

1 (as defined in section 1903(m)) or to an entity furnishing
2 services under a waiver approved under section 1915(b)(1),
3 the State must provide that it will exclude from participation,
4 as such an organization or entity, any organization or entity
5 that—

6 “(A) could be excluded under section 1128(b)(8)
7 (relating to owners and managing employees who have
8 been convicted of certain crimes or received other
9 sanctions), or

10 “(B) has, directly or indirectly, a substantial con-
11 tractual relationship (as defined by the Secretary) with
12 an individual or entity that is described in section
13 1128(b)(8)(B).

14 “(3) As used in this subsection, the term ‘exclude’ in-
15 cludes the refusal to enter into a participation agreement or
16 the termination of such an agreement.”.

17 SEC. 8. MISCELLANEOUS AND CONFORMING AMENDMENTS.

18 (a) MATERNAL AND CHILD HEALTH PROGRAM.—Sec-
19 tion 504(b) (42 U.S.C. 704(b)) is amended—

20 (1) by striking out “or” at the end of paragraph
21 (4),

22 (2) by striking out the period at the end of para-
23 graph (5) and inserting in lieu thereof “; or”, and

24 (3) by adding at the end thereof the following new
25 paragraph:

1 “(6) payment for any item or service furnished by
2 an individual or entity excluded from participation in
3 the program under this title pursuant to section 1128
4 or section 1128A.”.

5 (b) DISCLOSURE REQUIREMENTS.—(1) Subsection (a)
6 of section 1126 (42 U.S.C. 1320a-5) is amended—

7 (A) in the first sentence, by striking out “or other
8 institution” and all that follows through the period at
9 the end and inserting in lieu thereof “or other entity
10 (other than an individual practitioner or group of prac-
11 titioners) shall be required to disclose to the Secretary
12 or to the appropriate State agency the name of any
13 person who has an ownership or control interest (as
14 defined in section 1124(a)(3)) in such entity, or is a
15 managing employee (as defined in subsection (b)) of
16 such entity, and who is or has been excluded or sus-
17 pended from participation in a program under title
18 XVIII or in a State health care program described in
19 section 1128(g) or has been convicted of any criminal
20 offense on the basis of which the individual or entity
21 may be excluded from a program under section 1128.”,
22 and

23 (B) in the second sentence, by striking out “insti-
24 tution, organization, or agency” and inserting in lieu
25 thereof “entity”.

1 (2) Subsection (b) of such section is amended by striking
2 out "institution, organization, or agency" and inserting in
3 lieu thereof "entity" each place it appears.

4 (c) **MEDICARE PAYMENTS.**—(1) Section 1862 (42
5 U.S.C. 1395y) is amended—

6 (A) by striking out subsection (d), and

7 (B) by amending subsection (e) to read as follows:

8 “(e) No payment may be made under this title with re-
9 spect to any item or service furnished by an individual or
10 entity during any period when the individual or entity is ex-
11 cluded from participation in a program under this title pursu-
12 ant to section 1128 or section 1128A.”.

13 (2) Sections 1842(j)(2)(A) and 1862(h)(4) (42 U.S.C.
14 1395u(j)(2)(A), 1395y(h)(4)) are each amended by striking out
15 “paragraphs (2) and (3) of section 1862(d)” and inserting in
16 lieu thereof “subsections (c), (d), and (f) of section 1128”.

17 (3) Paragraph (3) of section 1886(f) (42 U.S.C.
18 1395ww(f)) is amended to read as follows:

19 “(3) The provisions of subsections (c) through (f) of sec-
20 tion 1128 shall to apply to determinations made under para-
21 graph (2) in the same manner as they apply to exclusions
22 effected under section 1128(b)(6).”.

23 (d) **TERMINATION OF PROVIDER AGREEMENTS UNDER**
24 **MEDICARE.**—Section 1866 (42 U.S.C. 1395cc) is amend-
25 ed—

1 (1) by striking out paragraph (3) of subsection (a);

2 (2) by amending subsection (b) to read as follows:

3 “(b)(1) A provider of services may terminate an agree-
4 ment with the Secretary under this section at such time and
5 upon such notice to the Secretary and the public as may be
6 provided in regulations, except that notice of more than six
7 months shall not be required.

8 “(2) The Secretary may refuse to enter into an agree-
9 ment under this section or, upon such reasonable notice to
10 the provider and the public as may be specified in regula-
11 tions, may refuse to renew or may terminate such an agree-
12 ment after the Secretary—

13 “(A) has determined that the provider fails to
14 comply substantially with the provisions of the agree-
15 ment, with the provisions of this title and regulations
16 thereunder, or with a corrective action required under
17 section 1886(f)(2)(B),

18 “(B) has determined that the provider fails sub-
19 stantially to meet the applicable provisions of section
20 1861, or

21 “(C) has excluded the provider from participation
22 in a program under this title pursuant to section 1128
23 or section 1128A.

24 “(3) A termination of an agreement or a refusal to
25 renew an agreement under this subsection (and a termination

1 of approval of a supplier under this title) shall be effective on
 2 the same date, and with respect to the same items and serv-
 3 ices, as an exclusion from participation under the programs
 4 under this title would become effective under section
 5 1128(c)(1).”;

6 (3) by inserting “or has not been renewed” in
 7 paragraphs (1) and (3) of subsection (c) after “terminat-
 8 ed”; and

9 (4) by inserting “or nonrenewal” in subsection (c)
 10 after “termination”.

11 (e) OVERLAP WITH MEDICARE SANCTIONS.—Section
 12 1869(c) (42 U.S.C. 1395ff(c)) is amended by inserting before
 13 the period at the end thereof the following: “, except that an
 14 institution or agency is not entitled to separate notice and
 15 opportunity for a hearing under both section 1128 and this
 16 section with respect to a determination or determinations
 17 based on the same underlying facts and issues”.

18 (f) MEDICAID PLAN REVISIONS.—Section 1902(a) (42
 19 U.S.C. 1396b(a)) is amended—

20 (1) in paragraph (38), by striking out “respective-
 21 ly, (A)” and all that follows up to the semicolon at the
 22 end and inserting in lieu thereof “the information de-
 23 scribed in section 1128(b)(9)”, and

24 (2) in paragraph (39)—

1 (A) by striking out “bar” and inserting in
2 lieu thereof “exclude”,

3 (B) by striking out “person” and inserting in
4 lieu thereof “individual or entity” each place it
5 appears, and

6 (C) by inserting “or section 1128A” after
7 “section 1128”.

8 (g) DENIAL OF FEDERAL FINANCIAL PARTICIPATION
9 UNDER MEDICAID.—Paragraph (2) of section 1903(i) (42
10 U.S.C. 1396b(i)) is amended to read as follows:

11 “(2) with respect to any amount expended for
12 items or services furnished under the plan by any indi-
13 vidual or entity during any period when the individual
14 or entity is excluded from participation in the State
15 plan under this title pursuant to section 1128 or sec-
16 tion 1128A; or”.

17 (h) MEDICAID DISCLOSURE REQUIREMENTS.—Section
18 1903(n) (42 U.S.C. 1396b(n)) is amended by striking out
19 “has a direct or indirect ownership or control interest of 5
20 percent or more” and inserting in lieu thereof “is a person
21 with an ownership or control interest (as defined in section
22 1124(a)(3))”.

23 (i) TITLE XX.—Section 2005(a) (42 U.S.C. 1397d(a)) is
24 amended—

1 (1) by striking out "or" at the end of paragraph
2 (7),

3 (2) by striking out the period at the end of para-
4 graph (8) and inserting in lieu thereof "; or", and

5 (3) by adding at the end thereof the following new
6 paragraph:

7 "(9) for payment for any item or service furnished
8 by a person excluded from participation in the program
9 under this title pursuant to section 1128 or section
10 1128A."

11 **SEC. 9. EFFECTIVE DATES.**

12 (a) **IN GENERAL.**—Except as provided in subsections
13 (b) and (c), the amendments made by this Act shall become
14 effective at the end of the 14-day period beginning on the
15 date of the enactment of this Act and shall not apply to ad-
16 ministrative proceedings commenced before the end of such
17 period.

18 (b) **MANDATORY MINIMUM EXCLUSIONS APPLY PRO-**
19 **SPECTIVELY.**—Subparagraph (A) of section 1128(f)(1) of the
20 Social Security Act (as amended by this Act), insofar as it
21 requires an exclusion of not less than five years in the case
22 described in section 1128(a) of that Act, shall not apply to
23 exclusions based on convictions occurring before the date of
24 the enactment of this Act.

1 (c) EFFECTIVE DATE FOR CHANGES IN MEDICAID

2 LAW.—(1) The amendments made by sections 5 and 8(f)
3 apply (except as provided under paragraph (2)) to payments
4 under title XIX of the Social Security Act for calendar quar-
5 ters beginning more than 30 days after the date of the enact-
6 ment of this Act.

7 (2) In the case of a State plan for medical assistance
8 under title XIX of the Social Security Act which the Secre-
9 tary of Health and Human Services determines requires
10 State legislation in order for the plan to meet the additional
11 requirements imposed by the amendments made by this Act,
12 the State plan shall not be regarded as failing to comply with
13 the requirements of such title solely on the basis of its failure
14 to meet these additional requirements before the first day of
15 the first calendar quarter beginning after the close of the first
16 regular session of the State legislature that begins after the
17 date of the enactment of this Act.

18 (3) Subsection (j) of section 1128A of the Social Securi-
19 ty Act (as added by section 3(f) of this Act) takes effect on
20 the date of the enactment of this Act.

99TH CONGRESS
1ST SESSION

H. R. 1091

To amend titles XI, XVIII, and XIX of the Social Security Act to provide for civil monetary and criminal penalties for an individual who has made a material misrepresentation in order to be licensed as a physician and for whose services payments are made under the medicare or medicaid programs.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 7, 1985

Mr. WYDEN (for himself and Mr. PEPPER) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

A BILL

To amend titles XI, XVIII, and XIX of the Social Security Act to provide for civil monetary and criminal penalties for an individual who has made a material misrepresentation in order to be licensed as a physician and for whose services payments are made under the medicare or medicaid programs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 CIVIL MONETARY PENALTY FOR PHYSICIAN

2 MISREPRESENTATIONS

3 SECTION 1. (a) ADDITIONAL CIVIL MONETARY PENAL-
4 TIES.—Section 1128A(a)(1) of the Social Security Act (42
5 U.S.C. 1320a-7a(a)(1)), relating to grounds for the imposi-
6 tion of civil monetary penalties, is amended—

7 (1) by striking out “is for a medical or other item
8 or service”;

9 (2) by inserting “is for a medical or other item or
10 service” in subparagraphs (A) and (B) after “(A)” and
11 “(B)”, respectively;

12 (3) by striking out “or” at the end of subpara-
13 graph (A);

14 (4) by striking out the “; or” at the end of sub-
15 paragraph (B) and inserting in lieu thereof a comma;
16 and

17 (5) by inserting after subparagraph (B) the follow-
18 ing new subparagraph:

19 “(C) is presented for a physician’s service by
20 a person who knows or has reason to know that
21 the individual who furnished the service either—

22 “(i) was not licensed as a physician,

23 “(ii) was licensed as a physician, but
24 such license had been obtained through a
25 misrepresentation of material fact (including

1 cheating on an examination required for li-
 2 censing), or

3 “(iii) represented to the patient at the
 4 time the service was furnished that the phy-
 5 sician was certified in a medical specialty by
 6 a medical specialty board when the individ-
 7 ual was not so certified; or”.

8 (b) EFFECTIVE DATE.—The amendments made by sub-
 9 section (a) apply to claims presented for physician’s services
 10 performed on or after the date of the enactment of this Act,
 11 without regard to the date the misrepresentation of fact was
 12 made.

13 CRIMINAL PENALTIES FOR PHYSICIAN

14 MISREPRESENTATIONS

15 SEC. 2. (a) UNDER MEDICARE.—Section 1877(a) of the
 16 Social Security Act (42 U.S.C. 1395nn(a)), relating to crimi-
 17 nal penalties under the medicare program, is amended—

18 (1) by striking out “or” at the end of paragraph
 19 (3),

20 (2) by inserting “or” at the end of paragraph (4),
 21 and

22 (3) by inserting after paragraph (4) the following
 23 new paragraph:

24 “(5) presents a claim for a physician’s service for
 25 which payment may be made under this title and

1 knows or has reason to know that the individual who
2 furnished the service either—

3 “(A) was not licensed as a physician,

4 “(B) was licensed as a physician, but such li-
5 cense had been obtained through a misrepresenta-
6 tion of material fact (including cheating on an ex-
7 amination required for licensing), or

8 “(C) represented to the patient at the time
9 the service was furnished that the physician was
10 certified in a medical specialty by a medical spe-
11 cialty board when the individual was not so certi-
12 fied,”.

13 (b) UNDER MEDICAID.—Section 1909(a) of the Social
14 Security Act (42 U.S.C. 1396h(a)), relating to criminal pen-
15 alties under the medicaid program, is amended—

16 (1) by striking out “or” at the end of paragraph
17 (3),

18 (2) by inserting “or” at the end of paragraph (4),
19 and

20 (3) by inserting after paragraph (4) the following
21 new paragraph:

22 “(5) presents a claim for a physician’s service for
23 which payment may be made under a State plan ap-
24 proved under this title and knows or has reason to

1 know that the individual who furnished the service
2 either—

3 “(A) was not licensed as a physician,

4 “(B) was licensed as a physician, but such li-
5 cense had been obtained through a misrepresenta-
6 tion of material fact (including cheating on an ex-
7 amination required for licensing), or

8 “(C) represented to the patient at the time
9 the service was furnished that the physician was
10 certified in a medical specialty by a medical spe-
11 cialty board when the individual was not so certi-
12 fied,”.

13 (c) EFFECTIVE DATE.—The amendments made by sub-
14 sections (a) and (b) apply to claims presented for physician’s
15 services performed on or after the date of the enactment of
16 this Act, without regard to the date the misrepresentation of
17 fact was made.

9TH CONGRESS
1ST SESSION

H. R. 1369

To amend the Controlled Substances Act and Title XI of the Social Security Act to deny, revoke, or suspend the registration to manufacture, distribute or dispense a controlled substance for entities excluded from the medicare program.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 28, 1985

Mr. MOORE (for himself, Mr. WAXMAN, Mr. STARK, Mr. GRADISON, Mr. RANGEL, Mr. PEPPER, Mr. GEPHARDT, and Mr. WYDEN) introduced the following bill; which was referred to the Committee on Ways and Means and Energy and Commerce

A BILL

To amend the Controlled Substances Act and Title XI of the Social Security Act to deny, revoke, or suspend the registration to manufacture, distribute or dispense a controlled substance for entities excluded from the medicare program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 SECTION 1. DENIAL, REVOCATION, OR SUSPENSION OF REGIS-
2 TRATION TO MANUFACTURE, DISTRIBUTE, OR
3 DISPENSE A CONTROLLED SUBSTANCE FOR EN-
4 TITIES EXCLUDED FROM THE MEDICARE PRO-
5 GRAM.

6 (a) IN GENERAL.—Section 304(a) of the Controlled
7 Substances Act (21 U.S.C. 824(a)) is amended—

8 (1) by striking out “or” at the end of paragraph

9 (2),

10 (2) by striking out the period at the end of para-
11 graph (3) and inserting in lieu thereof “; or”, and

12 (3) by inserting after paragraph (3) the following
13 new paragraph:

14 “(4) has been excluded from participation in a
15 program under title XVIII of the Social Security Act
16 pursuant to section 1128(a) of that Act.”.

17 (b) CONFORMING AMENDMENTS TO SOCIAL SECURITY
18 ACT.—Subsections (e)(1) and (f)(4) of section 1128 of the
19 Social Security Act, as amended by section 2 of the Medicare
20 and Medicaid Patient and Program Protection Act of 1985,
21 are each amended by inserting “(and, in the case of an exclu-
22 sion effected pursuant to subsection (a) and to which section
23 304(a)(4) of the Controlled Substances Act may apply, the
24 Attorney General)” after “each State health care program”.

**STATEMENTS OF MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR,
HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING
OFFICE, ACCOMPANIED BY TOM DOWDAL; AND RICHARD P.
KUSSEROW, INSPECTOR GENERAL, DEPARTMENT OF HEALTH
AND HUMAN SERVICES**

Mr. ZIMMERMAN. Thank you, Mr. Chairman.

Let me begin by introducing Mr. Tom Dowdal, who is seated to my left. Mr. Dowdal is responsible for our work in the Medicare area.

We are pleased to be here today to present our views on H.R. 1370, a bill to protect beneficiaries under health care programs of the Social Security Act from unfit practitioners and entities. Basically the bill consolidates the existing legislative authorities and provides new authorities to HHS to exclude unfit and unethical health care practitioners and entities from participating in the Act's health care programs.

Last year we testified before your subcommittees in support of a similar bill, H.R. 5989. At that hearing we presented details on our May 1, 1984, report entitled "Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients From Health Practitioners Who Lose Their Licenses." Today I would like to briefly summarize that report and discuss provisions in H.R. 1370 that were not covered by our testimony last year.

In preparing our 1984 report, we analyzed the Social Security Act provisions authorizing HHS to exclude unfit and unethical practitioners from the Medicare and Medicaid Programs. Our analysis was directed at identifying gaps in these authorities, and we found that practitioners who lose their license to participate in Medicaid in one State, for such reasons as the habitual overprovision of health services, can continue to practice under Medicare in that State or relocate to another where they hold a license and practice under both programs.

We also found that practitioners who lose their right to participate in Medicare for such reasons as providing inappropriate care, can continue to participate in Medicaid in any State where they hold a license.

In addition, we found that practitioners convicted of crimes other than Medicare and Medicaid fraud, such as defrauding private insurance and illegally trafficking in drugs, can continue to practice under both programs.

We believe, in the situations I just outlined, HHS's should be able to nationally exclude practitioners from both Medicare and Medicaid, because in each case the practitioner had been found to be unfit or unethical by one of the programs or the criminal court system.

We also identified a fourth major gap in HHS' exclusion authority. We noted that a practitioner licensed in more than one State could have one of the licenses suspended or revoked by State licensing boards, relocate to another State, and continue to treat Medicare and Medicaid patients. In these instances, Federal beneficiaries would be treated by a practitioner who had been determined by a licensing board in another State to be unfit to provide care.

The report presents a number of examples why practitioners lost their licenses and how they continued to see Medicare and Medicaid patients. The reasons the practitioners lost their licenses involved serious matters, ranging from drug addiction and sexual abuse of patients to mental incompetence and the unnecessary provision of dangerous medical procedures.

To better protect Federal beneficiaries from unfit and unethical practitioners, we recommended that HHS request legislation to close these four gaps in its exclusion authorities. We understand that in response to our recommendation, the inspector general's office has worked with the sponsors of H.R. 1370 in developing that bill. H.R. 1370, if enacted, will close the gaps we identified, as well as make other changes in the Social Security Act's antifraud and abuse provisions that the inspector general believes are needed.

Now I would like to turn to the new provisions of H.R. 1370. The major difference between H.R. 5989 and H.R. 1370 is the inclusion of HMO's and similar type of prepaid health plans under contract with Medicaid or Medicare and entities operating under a waiver of Medicaid's freedom-of-choice requirement granted to the States by HHS.

Section 2 of H.R. 1370 would authorize the Secretary to exclude from Medicare and Medicaid HMO's, prepaid health plans, and entities operating under the cited Medicaid waiver, if they fail in a substantial number of cases to provide medically necessary items of services as required by law or their contracts with the program.

Section 7 of H.R. 1370 would also require States to provide that they will exclude these types of organizations if they are owned or controlled by or have substantial contractual relationships with individuals who have been convicted of certain crimes or who receive a civil monetary penalty or are excluded from Medicare or a State health program.

All of the entities covered by these provisions operate under contracts with the Federal or State Governments. These contracts give the entities incentives to closely control the utilization of health care services. This results because the entities are normally paid a fixed rate to furnish all the services covered by the contract that the program beneficiaries need. Thus, preventing the provision of unnecessary services helps the entity assure that its costs stay within the fixed payment it receives.

Under the incentives of these agreements, it is also possible—

Mr. STARK. Mr. Zimmerman, I'm sorry to interrupt, but we will have to interrupt your testimony now. I am sure that some of the rest of the points covered in your prepared testimony will be brought up by questions from the members, and I ask Mr. Kusserow if he would like to proceed to summarize or present as much as of his prepared testimony as possible. The full testimony will appear in the record.

And I might add that any members who have additional questions that they don't have time for, we'll ask the witnesses to respond to in writing. Both the questions submitted to the witnesses and the responses will appear in the record in their entirety.

[The prepared statement of Mr. Zimmerman follows:]

United States General Accounting Office
Washington, D.C. 20548

FOR RELEASE ON DELIVERY
EXPECTED AT 1 P.M. EST
TUESDAY, MARCH 19, 1985

STATEMENT OF MICHAEL ZIMMERMAN
ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION
BEFORE THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
AND
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES
ON H.R. 1370

Mr. Chairmen and Members of the Subcommittees:

We are pleased to be here today to present our views on H.R. 1370, a bill to give beneficiaries protection under the health care programs of the Social Security Act from unfit health care practitioners and entities. Basically, the bill consolidates the act's current legislative authorities for, and provides new authorities to, the Department of Health and Human Services (HHS) related to excluding unfit and unethical health care practitioners and entities from participation in the act's health care programs.

Last year we testified before your Subcommittees in support of a similar bill, H.R. 5989. At that hearing we presented details on our May 1, 1984, report Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients From Health Practitioners Who Lose Their Licenses (GAO/HRD-84-53). Today I would like to briefly summarize that report and discuss provisions in H.R. 1370 that were not covered by our testimony on H.R. 5989.

GAPS IN EXCLUSION AUTHORITIES NEED TO BE CLOSED

To prepare our 1984 report, we analyzed the Social Security Act provisions authorizing HHS to exclude unfit and unethical practitioners from the Medicare and Medicaid programs. Our analysis was directed at identifying gaps in these authorities, and we found that:

- Practitioners who lose their right to participate in Medicaid in one state for such reasons as habitual over-provision of health services can continue to practice under Medicare in that state or relocate to another where they hold a license and practice under both programs.
- Practitioners who lose their right to participate in Medicare for such reasons as providing inappropriate care can continue to participate in Medicaid in any state where they hold a license.

--Practitioners convicted of crimes other than Medicare and Medicaid fraud, such as defrauding private insurance or illicitly trafficking in drugs, can continue to practice under both programs.

We believe that in the situations outlined above, HHS should be able to nationally exclude practitioners from both Medicare and Medicaid because in each case the practitioner had been found to be unfit or unethical by one of the programs or the criminal court system.

We also identified a fourth major gap in HHS' exclusion authority. We noted that a practitioner licensed in more than one state could have one of these licenses suspended or revoked by a state licensing board but relocate to another state and continue to treat Medicare and Medicaid patients. In these instances, therefore, federal beneficiaries would be treated by a practitioner who had been determined by a licensing board in another state to be unfit to provide care.

We reviewed 328 practitioners who had been sanctioned by state licensing boards in Michigan, Ohio, and Pennsylvania and found that 122 of them held licenses in at least one state besides the state taking action against them. In total, these practitioners held licenses in 39 states and the District of Columbia. Of these 122 practitioners, 39 relocated and enrolled in the Medicare and/or Medicaid programs, 10 relocated but we identified no Medicare or Medicaid participation, and 43 could

have relocated because they still held licenses in other states but we could not determine their whereabouts. The report presents a number of examples of why practitioners lost their licenses and how they continued to see Medicare and Medicaid patients. The reasons the practitioners lost their licenses involved serious matters ranging from drug addiction and sexual abuse of patients to mental incompetence and the unnecessary provision of dangerous medical procedures.

To better protect federal beneficiaries from unfit and unethical practitioners, we recommended that HHS request legislation to close these four gaps in its exclusion authorities. We understand that in response to our recommendation, the HHS Inspector General's Office has worked with the sponsors of H.R. 1370 in developing that bill. We are pleased that the bill, if enacted, will close the gaps we identified as well as make other changes in the Social Security Act's antifraud and abuse provisions that the Inspector General believes are needed.

NEW PROVISIONS IN H.R. 1370

The major difference between H.R. 5989 and H.R. 1370 is the inclusion of (1) health maintenance organizations (HMOs) and similar types of prepaid health plans under contract with Medicare or Medicaid and (2) entities operating under a waiver of Medicaid's "freedom of choice" requirement granted to the state by HHS under section 1915(b)(1) of the Social Security Act.

H.R. 1370 (section 2, which would add section 1128(b)(6)(D) and (E) to the Social Security Act) would authorize the Secretary of HHS to exclude from Medicare and Medicaid HMOs, prepaid health plans, and entities operating under the cited Medicaid waiver if they fail in a substantial number of cases to provide medically necessary items or services as required by law or their contracts with the programs. H.R. 1370 (section 7) would also require states to provide that they will exclude HMOs, prepaid health plans, and entities operating under the waiver if they are owned or controlled by, or have substantial contractual relationships with, individuals who have been convicted of certain crimes or who received a civil monetary penalty or are excluded from Medicare or a state health care program.

All of the entities covered by these provisions operate under contracts with the federal or state governments; these contracts give the entities incentives to closely control the utilization of health care services. This results because the entities are normally paid a fixed rate to furnish all of the services covered by the contract that the program beneficiaries need. Thus, preventing the provision of unnecessary services helps the entity assure that its costs stay within the fixed payments it receives. Under the incentives of these agreements, it is also possible that entities could underprovide services in order to avoid a loss or to increase income.

We view the exclusion authority for denial of medically necessary services by HMOs, prepaid health plans, and entities operating under freedom of choice waivers as providing a deterrent to them against letting the incentives of their contracts work to their patients' medical disadvantage. We believe that providing such a deterrent is appropriate. The requirement in section 7 for states to provide for exclusion of HMOs, prepaid plans, and entities operating under the waiver basically calls for states to have available the same exclusion authority for entities as HHS would have under H.R. 1370. It would also extend the authority to provide a deterrent against unethical individuals gaining control over or advantage of these entities by means of contractual relationships. Again, we believe that such a deterrent is appropriate.

This concludes my prepared statement. We will be happy to answer any questions you may have.

Mr. STARK. Mr. Kusserow.

STATEMENT OF RICHARD P. KUSSEROW

Mr. KUSSEROW. Thank you, Mr. Chairman.

I am Richard P. Kusserow, Inspector General for the Department of Health and Human Services, and with me today from our General Counsel's staff is Craig Holden. We appreciate the opportunity to once again come before you and to express our views on this pending legislation which we consider to be valuable, if not really essential, to the enforcement of our Department's programs.

We feel it is vitally important that we protect the beneficiaries of our federally financed health care programs from those individuals who render inferior quality health care or who have robbed the trust funds through criminal acts.

It is also, we feel, the responsibility of professional organizations, State agencies and departments to assure quality health care for these beneficiaries. The passage of this bill will send a clear message that all of us will not tolerate the kinds of behavior that we have been observing over the last few years.

Under existing sanctioning authorities, health care professionals engaging in various improper practices can be suspended for participation in the Medicare-Medicaid Programs and/or financially penalized.

These authorities also provide for the termination of agreements between the department and hospitals, nursing homes and other institutions engaging in similar acts.

Our existing sanctions may be imposed on anyone who violates the Medicare-Medicaid Programs by, one, submitting false statements or claims for payment; or two, submitting or causing to be submitted bills or requests for payments containing charges substantially in excess of customary charges; three, furnishing services which are determined to be substantially in excess of the needs of the patient; four, furnishing services which are determined to be of quality failing to meet professionally recognized standards of health care; and finally, five, failing to keep adequate medical records to demonstrate the need for services rendered.

In addition, criminal convictions relating to either Medicare or Medicaid or grounds for suspension from those programs.

A provider sanctioned under any of the above authorities is excluded for specified periods of time. At the end of that time, the provider may reapply for the programs.

The State and local agencies responsible for licensing or certification are always notified of any suspension and frequently invoke a sanction of their own in accordance with applicable State law and policy.

Since assuming the sanction authorities in January 1983, on behalf of the Secretary, our office has imposed 674 sanctions on various health care providers. This is over twice the number of the previous 11 years of the authority combined in our Department.

In addition, since 1983, pursuant to new monetary penalty authorities, we have collected through successful implementations of that program more than \$9 million for recycling for the health care programs.

We have made substantial progress with these authorities. However, as we became more experienced with these programs, we began to see their shortcomings. In pursuing our aggressive program of administering sanctions over the past 2 years, we have identified several major loopholes in the authorities which have frustrated our goal of ridding the health care programs from corrupt or incompetent health care professionals.

Presently, the Government is unable to bar individuals or health care entities that have been convicted of defrauding other Federal, State or local programs, patient neglect or abuse, or unlawful manufacture, distribution or dispensing of controlled substances.

In addition, practitioners who lose or surrender their license in one State can move to another and continue the practice in our programs unabated. A glimpse of the extent of that was given by GAO in their recent report.

We are further inhibited by loopholes that exist for providers who are kicked out for criminal actions against our program. They can continue to maintain their Medicaid-Medicare patients for long periods of time, using various subterfuges. We have found this to be more the rule than the exception.

We therefore find that convicted providers will expend inordinate efforts and resources in trying to litigate periods of exclusion down so they may maintain their practice on our programs. This is the reason why we agree that 5 years minimum exclusion would be appropriate to eliminate that problem.

We have had a number of other problems that have come to our attention; more than 100 serious cases of the types that are described in our prepared testimony. But, for example, we have situations where we couldn't deal with existing authority, such as in Massachusetts, we have a physician who was convicted for assault and battery on a 14-year-old patient. We could take no action against them.

In Louisiana, a physician was convicted of 15 felony counts, including bank fraud, wire fraud, false entries in books and records, and conspiracy. We can do nothing about that.

In Pennsylvania, a physician was convicted of grand theft and transportation of stolen goods. Can't do anything about him, either.

In Indiana, a physician was found guilty of 27 counts of violating the drug laws. We could take no action against him.

We feel that this pending legislation will provide us the kind of tool that would eliminate all the different types of abuses and close the loopholes that are so large that Mack truck might be able to drive through them at the present time.

And before concluding, we would like to also express our support of Mr. Wyden's companion efforts to provide for civil, monetary and criminal penalties for an individual who has made material representation in order to be licensed as a physician, and for whose services that payments were made under Medicare and Medicaid Programs.

And with that, Mr. Chairman, we will stand by to answer any questions you might have.

[The prepared statement of Mr. Kusserow follows:]

TESTIMONY
OF
RICHARD P. KUSSEROW
INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

GOOD AFTERNOON, MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I AM RICHARD P. KUSSEROW, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES. I APPRECIATE THE OPPORTUNITY TO DISCUSS H.R. 1370 - THE MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1984. AS YOU KNOW, I TESTIFIED LAST YEAR ON SIMILAR LEGISLATION INTRODUCED AND SPONSORED BY MEMBERS OF THESE COMMITTEES AND IT GIVES ME GREAT PLEASURE TO SEE THE BILL REINTRODUCED THIS YEAR, SO EARLY INTO THE NEW CONGRESS. NEEDLESS TO SAY, I TOTALLY SUPPORT THIS BILL.

THIS AFTERNOON, I WOULD LIKE TO SHARE WITH YOU AGAIN THE EXPERIENCE OF THE OFFICE OF INSPECTOR GENERAL IN EXERCISING OUR AUTHORITIES TO IMPOSE PENALTIES AND SANCTIONS AGAINST HEALTH CARE PROFESSIONALS WHO DEFRAUD OR ABUSE THE MEDICARE OR MEDICAID PROGRAMS. IT IS VITALLY IMPORTANT THAT WE PROTECT THE BENEFICIARIES OF OUR FEDERALLY FINANCED HEALTH CARE PROGRAMS FROM THOSE INDIVIDUALS WHO RENDER INFERIOR QUALITY HEALTH CARE. OUR BENEFICIARIES OFTEN DO NOT HAVE THE ABILITY TO INVESTIGATE A PHYSICIAN'S BACKGROUND CONCERNING HIS OR HER PROFESSIONAL AND PERSONAL REPUTATION AND WHETHER HE OR SHE IS ABLE TO SUPPLY QUALITY HEALTH CARE. IN MANY CASES BENEFICIARIES HAVE LITTLE CHOICE AS TO WHO WILL TREAT THEM. IT IS THIS DEPARTMENT'S RESPONSIBILITY TO ASSURE THE QUALITY HEALTH CARE FOR THESE BENEFICIARIES. PASSAGE OF THIS BILL WILL SEND A CLEAR MESSAGE THAT WE WILL NOT PERMIT OUR BENEFICIARIES TO RECEIVE SECOND CLASS HEALTH CARE.

THE OFFICE OF INSPECTOR GENERAL IS ALSO COMMITTED TO STOPPING HEALTH CARE RIPOFFS AND INSURING THAT OUR SCARCE HEALTH CARE FUNDS REACH THE AGED AND DISADVANTAGED.

SINCE 1983, WE HAVE ACTIVELY WORKED TO MEET THE MISSION OF SANCTIONING AND PENALIZING HEALTH PROVIDERS WHO ATTEMPT TO DEFRAUD THE SYSTEM. IN THAT YEAR, SECRETARY HECKLER TRANSFERRED TO THE INSPECTOR GENERAL'S OFFICE FROM THE HEALTH CARE FINANCING ADMINISTRATION THE AUTHORITY TO SUSPEND OR TERMINATE FROM PARTICIPATION IN MEDICARE/MEDICAID ALL HEALTH CARE PROVIDERS WHO ENGAGE IN FRAUDULENT OR ABUSIVE PRACTICES. DURING THE SAME TIME PERIOD, THE CIVIL MONEY PENALTIES LAW (CMPL), PROVIDING FOR TOUGH FINES, WAS FORMALLY IMPLEMENTED BY THE DEPARTMENT, FURTHER EMPOWERING THE INSPECTOR GENERAL TO TAKE ACTION AGAINST HEALTH PROVIDERS WHO ABUSE OR DEFRAUD THESE PROGRAMS. IN ADDITION UNDER THE DEFICIT REDUCTION ACT OF 1984, WE RECEIVED NEW AUTHORITY TO LEVY MONETARY PENALTIES AND SANCTIONS AGAINST PHYSICIANS WHO VIOLATE THE FREEZE ON THE FEES CHARGED TO BENEFICIARIES.

UNDER THESE SANCTIONING AUTHORITIES, HEALTH CARE PROFESSIONALS ENGAGING IN IMPROPER PRACTICES CAN BE SUSPENDED FROM PARTICIPATION IN THE MEDICARE AND MEDICAID PROGRAMS AND/OR FINANCIALLY PENALIZED. THESE AUTHORITIES ALSO PROVIDE FOR TERMINATION OF AGREEMENTS BETWEEN THE DEPARTMENT AND HOSPITALS, NURSING HOMES, AND OTHER INSTITUTIONS ENGAGING IN SIMILAR ACTS.

UNDER VARIOUS SECTIONS OF THE SOCIAL SECURITY ACT AS AMENDED, OUR EXISTING ADMINISTRATIVE SANCTIONS MAY BE IMPOSED ON ANYONE WHO:

- (1) SUBMITS FALSE STATEMENTS OR CLAIMS FOR PAYMENT;
- (2) SUBMITS, OR CAUSES TO BE SUBMITTED, BILLS OR REQUESTS FOR PAYMENT CONTAINING CHARGES SUBSTANTIALLY IN EXCESS OF CUSTOMARY CHARGES;
- (3) FURNISHES SERVICES WHICH ARE DETERMINED TO BE SUBSTANTIALLY IN EXCESS OF THE NEEDS OF PATIENTS;
- (4) FURNISHES SERVICES WHICH ARE DETERMINED TO BE OF QUALITY FAILING TO MEET PROFESSIONALLY RECOGNIZED STANDARDS OF HEALTH CARE;
- (5) FAILS TO KEEP ADEQUATE MEDICAL RECORDS TO DEMONSTRATE THE NEED FOR SERVICES RENDERED.

IN ADDITION, CRIMINAL CONVICTIONS RELATING TO EITHER MEDICARE OR MEDICAID ARE GROUNDS FOR SUSPENSION FROM THOSE PROGRAMS.

A PROVIDER SANCTIONED UNDER ANY OF THE ABOVE AUTHORITIES IS EXCLUDED FOR SPECIFIED PERIODS OF TIME. AT THE END OF THE PERIOD, THE PROVIDER MAY APPLY FOR REINSTATEMENT BUT REINSTATEMENT TO THE PROGRAMS IS CONTINGENT ON OUR DETERMINATION THAT THE OFFENSE IS NOT LIKELY TO RECUR. .

THE STATE AND LOCAL AGENCIES RESPONSIBLE FOR LICENSING OR CERTIFICATION ARE ALWAYS NOTIFIED OF THE SUSPENSION AND FREQUENTLY INVOKE A SANCTION IN ACCORDANCE WITH APPLICABLE STATE LAW OR POLICY.

SINCE RECEIVING THE SANCTION AUTHORITY IN JANUARY 1983, THE OIG HAS IMPOSED 674 SANCTIONS ON VARIOUS HEALTH CARE PROVIDERS.

THE CIVIL MONEY PENALTIES AUTHORITY PROVIDES ANOTHER SANCTION TOOL IN THESE EFFORTS. THE LAW WAS DESIGNED TO DEAL WITH PROVIDERS WHO SUBMIT BILLS FOR ITEMS OR SERVICES NOT PROVIDED AS CLAIMED. IT HITS DEFRAUDERS WHERE IT HURTS --IN THE POCKETBOOK. OVER AND ABOVE ANY PROSECUTORIAL ACTION, THE DEPARTMENT NOW HAS THE AUTHORITY TO IMPOSE ASSESSMENTS AND PENALTIES TO RECOVER DOLLARS LOST AS A RESULT OF THE SUBMISSION OF FALSE CLAIMS. THE LAW PERMITS AN ASSESSMENT OF UP-TO-TWICE THE AMOUNT CLAIMED AGAINST ANY PERSON OR ORGANIZATION WHO KNOWS OR HAS REASON TO KNOW THAT ITEMS OR SERVICES WERE NOT PROVIDED AS CLAIMED. IN ADDITION, NOT MORE THAN \$2,000 PER EACH ITEM OR SERVICE IMPROPERLY CLAIMED MAY ALSO BE LEVIED AS A PENALTY. THIS INSURES THAT THERE IS NO UNJUST ENRICHMENT OF WRONGDOERS AND THAT THEY PAY A SUBSTANTIAL PENALTY.

SINCE 1983, WE HAVE COLLECTED MORE THAN \$9 MILLION FOR RECYCLING TO THE HEALTH CARE PROGRAMS.

UNQUESTIONABLY, THE CIVIL MONEY PENALTIES LAW AND THE NEW SUSPENSION-EXCLUSION AUTHORITY ARE POTENT WEAPONS. COUPLED WITH THE FACT THAT HEALTH CARE PROVIDERS NOW FACE AN INCREASED RISK OF IMPRISONMENT, THESE SANCTIONS SHOULD UNDERSCORE THE MESSAGE THAT THE TOTAL RESOURCES OF OUR OFFICE ARE MASSED IN AN ALL-OUT EFFORT TO ROOT OUT THOSE FEW WHO WOULD TARNISH THEIR PROFESSIONS BY PREYING ON THE MEDICARE/MEDICAID PROGRAMS OR ON INNOCENT BENEFICIARIES AND RECIPIENTS OF THE SERVICES PROVIDED BY THOSE PROGRAMS. THAT SHOULD GO A LONG WAY TO CONVINCING POTENTIAL WRONGDOERS THAT THEIR CRIMES WILL BE SWIFTLY PUNISHED.

HOWEVER, AS WE BECAME MORE EXPERIENCED WITH THESE PROGRAMS, WE ALSO BEGAN TO SEE THEIR SHORTCOMINGS. IN PURSUING OUR AGGRESSIVE PROGRAM OF ADMINISTRATIVE SANCTIONS OVER TWO PAST YEARS, WE HAVE IDENTIFIED NUMEROUS DEFICIENCIES IN OUR AUTHORITIES WHICH HAVE FRUSTRATED OUR GOAL OF RIDDING THE HEALTH CARE PROGRAMS FROM CORRUPT OR INCOMPETENT HEALTH CARE PROFESSIONALS. AT PRESENT, I AM UNABLE TO BAR INDIVIDUALS OR HEALTH CARE ENTITIES WHO HAVE BEEN CONVICTED OF:

1. DEFRAUDING PRIVATE HEALTH INSURERS;
2. DEFRAUDING OTHER FEDERAL, STATE, OR LOCAL PROGRAMS;
3. PATIENT NEGLECT OR ABUSE; OR
4. UNLAWFUL MANUFACTURE, DISTRIBUTION, OR DISPENSING OF CONTROLLED SUBSTANCES.

OVER THE PAST TWO YEARS NUMEROUS CASES HAVE BEEN REFERRED TO ME ILLUSTRATING THESE SHORTCOMINGS. FOR EXAMPLE: JUST IN THE PAST THREE MONTHS MORE THAN 100 SERIOUS CASES HAVE BEEN REPORTED TO MY OFFICE WHICH I HAVE NO AUTHORITY TO ACT UPON INVOLVING PHYSICIANS AND HEALTH CARE PROFESSIONALS WHO POSE A THREAT TO THE HEALTH AND SAFETY OF MEDICARE AND MEDICAID BENEFICIARIES OR TO THE FINANCIAL INTEGRITY OF THE PROGRAMS. IN REVIEWING THESE CASES I HAVE FOUND THAT 84 INVOLVE PHYSICIANS WHO HAVE LOST THEIR LICENSES DUE TO DRUG VIOLATIONS, GROSS NEGLIGENCE, OR PROFESSIONAL INCOMPETENCE. ANOTHER 10 PHYSICIANS WERE CONVICTED OF VIOLATING DRUG LAWS, FOUR OTHERS WERE CONVICTED OF DEFRAUDING PRIVATE HEALTH CARE PROGRAMS. THE FOLLOWING CASES ILLUSTRATE WHY IT IS URGENT THAT CONGRESS PASS THIS LEGISLATION TO EMPOWER ME TO PROTECT THE HEALTH PROGRAMS AND ITS BENEFICIARIES FROM THESE IMMORAL AND DEPRAVED INDIVIDUALS:

- o IN MASSACHUSETTS, A PHYSICIAN WAS CONVICTED FOR ASSAULT AND BATTERY ON A 14 YEAR-OLD PATIENT.
- o IN LOUISIANA, A PHYSICIAN WAS CONVICTED OF 15 FELONY COUNTS INCLUDING BANK FRAUD, WIRE FRAUD, FALSE ENTRIES IN BOOKS AND RECORDS, AND CONSPIRACY.
- o IN PENNSYLVANIA, A PHYSICIAN WAS CONVICTED OF GRAND THEFT AND TRANSPORTATION OF STOLEN GOODS.

o IN INDIANA, A PHYSICIAN WAS FOUND GUILTY OF 27 COUNTS OF VIOLATING DRUG LAWS.

I HAVE NO AUTHORITY TO PROTECT BENEFICIARIES FROM THESE PERSONS, NOR, AM I ABLE IN MOST CASES TO SANCTION ENTITIES WHICH SUCH PERSONS OWN OR CONTROL; NOR, AM I CURRENTLY ABLE TO TAKE ADMINISTRATIVE ACTION WHERE THERE HAVE BEEN KICKBACKS, OR TO EXCLUDE PERSONS WHO HAVE LOST THEIR LICENSES TO PRACTICE IN ONE STATE AND HAVE MOVED TO ANOTHER TO PRACTICE.

THE PROVISIONS OF THIS BILL ADDRESS THESE CONCERNS. WE BELIEVE THAT MOST OF THE SECTIONS OF THIS BILL CAN BE IMPLEMENTED WITHIN A REASONABLE TIME THOSE PROVISIONS WHICH AFFECT THE CIVIL MONETARY PENALTIES PROGRAM ARE BASICALLY CLARIFYING PROVISIONS. IMMEDIATE ENACTMENT OF THESE PROVISIONS WOULD GREATLY BENEFIT THOSE HANDLING CMPL CASES. FOR EXAMPLE, UNDER THIS BILL, THE SECRETARY WILL HAVE THE AUTHORITY TO SEEK AN INJUNCTION AGAINST AN ALLEGED VIOLATOR TO PREVENT CONCEALING OR REMOVING ASSETS TO AVOID PAYING THE CIVIL MONEY PENALTY. ANOTHER SECTION ADDS A SIX YEAR STATUTE OF LIMITATION...EXISTING LAW DID NOT PROVIDE FOR THIS.

BEFORE CONCLUDING, I WOULD LIKE TO EXPRESS MY SUPPORT OF H.R. 1091, MR. WYDEN'S BILL TO PROVIDE FOR CIVIL MONETARY AND CRIMINAL PENALTIES FOR AN INDIVIDUAL WHO HAS MADE A MATERIAL MISREPRESENTATION IN ORDER TO BE LICENSED AS A PHYSICIAN AND FOR WHOSE SERVICE PAYMENTS ARE MADE UNDER THE MEDICARE AND MEDICAID PROGRAMS. WE HAVE TESTIFIED ON THIS SUBJECT BEFORE AND ARE PLEASED TO SEE THAT CONGRESS IS ACTING EXPEDITIOUSLY TO MAKE IT ABSOLUTELY CLEAR THAT THE AUTHORITY EXISTS TO CORRECT A VERY SERIOUS AND DISTURBING MATTER.

THANK YOU FOR THE OPPORTUNITY TO TESTIFY THIS MORNING. I STAND AVAILABLE TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Mr. STARK. Thank you very much for your cooperation.

I will ask Chairman Waxman if he would like to inquire at this point.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. Zimmerman, you indicated your support for the new provisions of the bill regarding the HMO's and providers operating under a Medicaid freedom-of-choice waiver.

Later in this hearing we will hear testimony that these provisions are redundant and unnecessary since there are other mechanisms already in place to sanction such providers if they fail to carry out their obligations.

Is this criticism valid, in your opinion?

Mr. ZIMMERMAN. Well, Mr. Chairman, we think the provision as proposed in the bill will serve as a useful deterrent. As it stands now in the law, on the fee-for-service situation, there is a provision for exclusion for overprovision of services. We think in this situation this would be a comparable position in a case of underprovision of services.

In terms of whether it is repetitive or overlaps with another provision of the law, I am not sure of that. Maybe Mr. Dowdal could offer some information on that point.

Mr. WAXMAN. Excuse me. Turn on your microphone.

Mr. STARK. Technology has passed this committee by, and you have to practically swallow those microphones for us to hear you.

Mr. DOWDAL. The only other provision that is directly related to this would be section 1156 dealing with the Professional Review Organizations, where they could, if they identified a pattern of underutilization, report that to the Secretary, and the Secretary could take action based upon that report.

That provision is designed more for the regular fee-for-service kind of environment too, and the way we feel is that these kinds of organizations have a different incentive system than generally found under fee-for-service, and it is appropriate to put in a deterrent provision in the act directed specifically at the underutilization of services.

Mr. WAXMAN. Mr. Kusserow, I understand at the present time there are several different procedural regulations drafted at different times by different agencies regarding the due process requirements under the various existing sanctions authorities.

This bill would consolidate these various sanctions authorities under Title XI of the Social Security Act. As we understand it, responsibility for implementation would also be consolidated under your control.

If that happens, do you intend to develop a general regulation establishing a unified set of procedures for all of these exclusion provisions?

Mr. KUSSEROW. Yes, Mr. Chairman. Secretary Heckler has already transferred all the sanctioning authorities in our department into the Office of Inspector General so as to avoid the possible confusion of different parts of the Department acting upon essentially the same fact situation. So we have already taken that first step.

Mr. WAXMAN. All right. Thank you very much.

Mr. STARK. Mr. Wyden.

Mr. WYDEN. Thank you very much, Mr. Chairman.

Mr. Kusserow, just one question for you: In my own State of Oregon, we recently learned of a medical degree mill where one man from Klamath Falls was arrested for fabricating medical and legal degrees for 2,500 people in years. He was also charged with selling fraudulent certificates of medical board membership.

Now it is my understanding that there may be as many as a dozen rings in this country operating in New York, in Florida, in Texas, in California, primarily, that are involved in DIPSCAM's, as we call them in Oregon, diploma scams, selling fraudulent medical degrees.

Would you care to comment on that, and how many rings you think there may be in this country?

Mr. KUSSEROW. Well, Mr. Wyden, I think that is a very conservative number. We have a major task force that involves the various Federal investigative agencies that are dealing with phony docs. That would include certainly the Postal Inspection Service, the FBI, and our own office and a number of other agencies, Federal State and Local.

What concerns me is not only is that a conservative figure in terms of diploma mills which are in the United States, but we have no idea how many diploma mills are overseas or outside the jurisdictional lines of the United States, doing exactly the same thing, and we don't know how many hundreds, if not thousands, of people are practicing medicine in the United States that have bogus degrees.

So we consider it an extremely serious problem. We consider what you just described more of the tip of the iceberg, rather than the iceberg itself.

Mr. WYDEN. Thank you. Mr. Chairman, in the interest of time, I won't ask any more questions.

Mr. STARK. Thank you, Mr. Wyden.

Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

First, I'd like to ask the Chair if it would be permissible for me to insert in the record a statement at this point.

Mr. STARK. Without objection, that will be done.

[The prepared statement of Mr. Moore follows:]

OPENING STATEMENT OF HON. W. HENSON MOORE

I want to express my appreciation to both Chairman Stark and Chairman Waxman, for providing this early hearing on H.R. 1370, the Medicare and Medicaid Patient and Program Protection Act of 1985.

Last year I, along with Chairman Waxman and several other colleagues, introduced a similar bill, H.R. 5989, which was reported favorably by the Ways and Means Committee shortly before the end of the session. Unfortunately, the clock ran out on the 98th Congress before the Subcommittee on Health of the Energy and Commerce Committee, which shares jurisdiction in this area, could act on the measure.

I am particularly pleased that Chairman Waxman is again cosponsoring the bill. I am equally pleased that our new Chairman of the Subcommittee on Health of the Committee on Ways and Means, Chairman Stark, and our new Ranking Minority Member, Bill Gradison, have joined as cosponsors.

The bill before us today reflects the improvements made last year by the Ways and Means Committee, as well as minor modifications recommended by the Inspector General of the Department of Health and Human Services, and minor changes recommended by Energy and Commerce Committee staff.

One section of last year's bill that would amend the Controlled Substance Act was introduced this year as a separate companion bill, H.R. 1369. This was done in order to avoid a potential conflict of jurisdiction with the Committee on Judiciary. It is my hope, however, that this companion bill will move in concert with the basic legislative package.

Also before us today is a bill introduced by Mr. Wyden and Mr. Pepper, H.R. 1091, which would provide monetary and criminal penalties for an individual who has made a material misrepresentation in order to be licensed as a physician, or who misrepresents himself or herself as a licensed physician. I support the gentleman from Oregon's proposal and commend him for his contribution to assure quality services to our nation's elderly and poor.

Mr. MOORE. Thank you.

I have a question for Mr. Kusserow.

We are going to hear testimony from the AMA later this afternoon in opposition to the proposed minimum 5-year exclusion upon conviction of a criminal offense. I believe the substance of their argument is that there are various levels of culpability and having a minimum 5-year sentence treats all people the same at that minimum heavy sentence level. And they think there ought to be discretion within the Secretary's office to be able to give anywhere from a 1- to 5-year exclusion.

We worked on this last year, and the committee last year kept the minimum sentence at 5 years. I would like for you to, at this time, restate your reasons for the record as to why you think it should be a minimum of 5 years.

Mr. KUSSEROW. When a physician is convicted by a jury of his peers for engaging in program fraud or abuse of patient that is related to one of our programs, it is my opinion that they should be excluded from all health care programs—indeed, all programs of the Federal Government—so long as the Earth spins on its axis.

However, if there are extremely mitigating circumstances, then we believe that there should be ways in which you can mitigate the effect of that. These circumstances mitigate against longer sentences. What we are recommending is a 5-year minimum sentence for persons already found guilty in a criminal court of law of a criminal offense.

I would also point out, Mr. Moore, that one of the problems that we have been finding is that a very large portion of those people which we have excluded pursuant to a conviction, criminal conviction, have expended enormous amounts of resources and time and energy in trying to get the period of their exclusion down. One of the reasons they are doing that is, as we are finding, that it's a pattern where these providers can maintain under various subterfuges their practice in both Medicare and Medicaid, oftentimes renting their space to a fellow practitioner to hold the practice alive while they go through their exclusion period.

Therefore, it is very important that they try to get exclusions down to within 2 years because if it gets over 2 years and up to 3 or 4 years, it gets more difficult to work out such arrangements or subterfuges.

We have found that a majority of the time spent in public hearing with ALJ's is not dealing with facts or guilt or innocent; rather it's dealing with arguments on how to get that number down. And these convicted practitioners or providers are willing to spend enormous resources to get their hands back into the program.

Mr. MOORE. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Pickle.

Mr. PICKLE. If you have discretion in the 5-year period, who would have the authority to mitigate or to allow the penalty to be less than 5 years?

Mr. KUSSEROW. If there was a criminal conviction, a criminal conviction either Federal or State, and it related to our programs, to Medicaid or to Medicare, the 5 years would be the minimum period, and that would go automatically with the criminal conviction.

The question is whether there would be discretion between over 5 years to a lifetime exclusion. We could bring down the lifetime exclusion to 5 years if it was due to cooperation of the convicted party, or for other mitigating circumstances. It is appropriate that they should be given a second chance in the program after they have cooled off for 5 years, and have demonstrated that in fact they are trustworthy enough to allow our patients to be exposed to them.

Mr. PICKLE. Well, then, if there is a crime perpetrated, and that person is barred, there would be a minimum of 5 years at least, and no discretion to that. If it's over that, then it could be. Is that authority left to the Secretary of HHS?

Mr. KUSSEROW. Under this proposed statute, that 5 years would be the minimum, and then whether it should be less than a lifetime exclusion would be under the authority of the Secretary to make that kind of decision, which again could be reviewed by an ALJ.

Mr. PICKLE. Is there any possibility that the individual, if convicted, could leave a company or an HMO and then go into another State and as an employee work for another organization?

Mr. KUSSEROW. It's possible. One of the things that this proposed legislation would provide for is allowing us to get at that kind of a problem. It's conceivable he might get away with it, but we feel that with this additional legislative authority, we'd be able to go to those other entities and hold them accountable for knowingly hiring a physician that was excluded or one that lost its license.

Mr. PICKLE. All right. Thank you, Mr. Chairman.

Mr. STARK. Mr. Coyne. Mr. Bates.

Mr. BATES. No questions.

Mr. STARK. We want to thank you very much for your testimony. We'll have some additional questions we'll submit to you for the record, and we'd appreciate your answers in writing.

Mr. KUSSEROW. Thank you, Mr. Chairman.

Mr. STARK. Thank you very much.

The next panel is Dr. John Ring, member of the board of trustees of the American Medical Association, and Dr. Robert Rosenberg, executive director of the Group Health Association of America.

Welcome to the committee, gentlemen. I apologize for the rules that are necessary. I'd ask you to proceed in any fashion that you'd care to, and if you'd reserve—I understand your testimony is how the American Medical Association is going to bail out 77 savings and loans in Ohio.

I'm sure that one member of our committee will find that most enlightening at this point. But if you will pardon my inside humor with our committee, I'd ask you to proceed in whatever order you see fit.

STATEMENTS OF JOHN J. RING, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY ROSS M. RUBIN, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION; AND ROBERT G. ROSENBERG, M.D., EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION, INC.

Dr. RING. Thank you, Mr. Chairman. I am John J. Ring, M.D., a physician in general practice in Illinois.

I am a member of the board of trustees of the American Medical Association.

Mr. STARK. Pardon me. Is your microphone on? Could you pull it closer? You have to get very close to it.

Dr. RING. Accompanying me today is Ross N. Rubin, director of AMA's Department of Federal Legislation. The AMA strongly supports efforts to root out fraud and abuse in Medicare and Medicaid, by whomever perpetrated, whether by physicians, dentists, pharmacists, podiatrists, optometrists, chiropractors, or any other providers.

Such reprehensible activity should not be tolerated under any circumstances, but at this time when program budgets are being cut, it is essential to deal with fraud and abuse aggressively.

One of the central features of previous hearings has focused on practitioners who have lost a license to practice within one State, and continue receiving reimbursement through federally funded programs when moving to another State.

Through cooperative efforts in using the AMA's physician master file, medical licensure boards in all States in which an individual has held or holds a license are now being alerted when that individual has been sanctioned in a different jurisdiction.

We have been issuing alerts on an average of 40 cases a month. We are now planning to increase our activities by focusing on information as to the date of a physician's death. Dissemination of information to States where our records show that a licensed physician is dead will allow States to purge the names of such physicians from State licensure lists and close yet another avenue of fraud.

Our data on deceased physicians has already proven to be a valuable tool in uncovering some fraudulent credentials of graduates of various Caribbean medical schools. Letters supposedly verifying students' clinical rotations have been uncovered which were allegedly signed by physicians, physicians whom we know to have been dead either at the time of the rotation or at the time the letters were signed.

Mr. Chairman, let me make clear our strong support for efforts to end fraud and abuse in Federal and State health care programs. Those who intentionally set out to rip off these programs should be prosecuted, and prosecuted to the fullest extent of the law.

With regard to H.R. 1370, the AMA supports the intent of this legislation. In our full statement we have detailed our concern with

specific provisions in the bill, and have offered suggestions for clarification. We are particularly concerned with provisions of the bill relating to the mandatory 5-year exclusion from health care programs, exclusion from the programs for administrative violations, HHS establishment of a central clearinghouse for State licensure actions, and authority to seize assets in anticipation of a possible violation.

We must oppose the companion bill, H.R. 1369, which authorizes the revocation or suspension of a practitioner's registration under the Controlled Substances Act because of certain exclusions from participation in Medicare. A penalty imposed by law should relate to the offense. Withdrawal of a practitioner's controlled substances registration for an offense totally unrelated to controlled substances practice is not appropriate, and this bill should not be adopted.

With regard to H.R. 1091, we support provisions which would authorize the Secretary to impose civil penalties and seek criminal sanctions against an individual who misrepresents himself as a licensed physician.

Another provision of H.R. 1091 applies civil and criminal penalties to an individual who has obtained the license through misrepresentation of material fact or cheating on a licensure examination.

We recommend modifications so that such sanctions under Medicare occur after the individual's license has been suspended or revoked by State licensure authority for misrepresentation or cheating.

The third category of sanctioned individuals would be those who hold themselves out to be board-certified specialists when in fact they are not so certified. It is not clear to us what the intent of this provision is, and who it is intended to cover.

For example, there are 23 medical specialty boards certifying in 29 areas which are recognized by the American Board of Medical Specialties and the American Medical Association. The other "boards"—and there are about 200 of them—do not have this recognition, and many corporate entities use the words "American Board" as part of their name in the health care area.

We note that criminal penalties would be imposed under the bill on those with knowledge or those having reason to know that there has been a misrepresentation. The existing criminal provisions being amended in the Social Security Act require conduct knowingly and willfully committed. We believe the criminal violation provisions of H.R. 1091 should reflect the same degree of intent.

The AMA will continue its efforts to address the problems created when sanctioned practitioners move to other jurisdictions, and we encourage States to fund adequately their medical licensing program.

We support efforts to close the gaps in the Secretary's authority which are discussed by the GAO in its report on physicians whose licenses are revoked for cause. We support the major thrust of both H.R. 1370 and H.R. 1091, and we'll be pleased to work with the committees to correct the problems with the bills which we have identified.

Thank you, Mr. Chairman. I'd be happy to answer any questions.

[Testimony resumes on p. 80.]

[Dr. Ring's prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
and the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives

Presented by

John J. Ring, M.D.

RE: H.R. 1370, Medicare and Medicaid Patient
and Program Protection Act of 1985

H.R. 1091, The Medical Impostors
Act of 1985

March 19, 1985

Mr. Chairman and Members of the Subcommittees:

I am John J. Ring, M.D. I am a physician in the general practice of medicine in Mundelein, Illinois, and I am a member of the American Medical Association's Board of Trustees. Accompanying me today is Ross N. Rubin, Director of AMA's Department of Federal Legislation.

The American Medical Association appreciates the opportunity to testify concerning H.R. 1370, the Medicare and Medicaid Patient and Program Protection Act, and H.R. 1091, the Medical Impostors Act.

INTRODUCTION

This is the third Congressional hearing within the past nine months concerning fraud and abuse by physicians in Medicare and Medicaid. Mr. Chairman, the AMA has appeared at the previous hearings and now at this time again states its strong support for efforts to root out fraud and abuse in these important programs by whomever perpetrated--whether by physicians, dentists, pharmacists, podiatrists, optometrists, chiropractors or other providers. Such reprehensible activities should not be tolerated under any circumstances, and at this time, in particular, when program budgets are being cut, it is essential to deal with program fraud and abuse aggressively. A dollar fraudulently diverted means a dollar not available for covered services to beneficiaries. Fraud and abuse should be ferreted out of all government programs whether they relate to health, food, housing, defense, or whatever. Taxpayers--and beneficiaries--deserve such accountability.

One of the central features of the various hearings has focused on practitioners who have lost a license to practice within one state and continue receiving reimbursement through federally-funded programs by moving to another state. I testified before the Senate Special Committee on Aging at the time of the release of a General Accounting Office report on this subject. At that time I stated--and as we previously had discussed with GAO--that the AMA was gravely concerned that health care practitioners who have been found unfit to practice in one jurisdiction could relocate and practice in another jurisdiction where they hold a license. These practitioners discredit their professions and subvert procedurally the state licensure programs in our nation. State licensure

has been, and continues to be, a major factor in assuring the high quality of health care available to all citizens. Its integrity must not be diminished.

I also stated to the Senate Committee several activities the AMA would undertake to address this disturbing problem and close any loopholes. Through cooperative efforts with state authorities and the Federation of State Medical Licensure Boards, information on licensure actions and revocations is made available to the AMA on a monthly basis. It was intended--using the AMA's unique database, the physician masterfile--that medical licensure boards in all states in which an individual has held or holds a license would be alerted when that individual has been sanctioned in a different jurisdiction. This effort allows states to act promptly against physicians who are the subject of state licensure actions. It protects the entire patient population, not just federal program beneficiaries. Mr. Chairman, I am pleased to state that these activities are now being carried out.

With information supplied by the Federation of State Medical Licensure Boards, we have been issuing alerts on an average of 40 cases a month.

We are now planning to increase our activities in this area by focusing on another unique aspect of our database-- information as to the date of a physician's death. This information is not always known by the state licensure boards and there have been cases where individuals will fraudulently renew and assume the credentials of a deceased physician. Our efforts to disseminate this information to states where our records

show that a licensed physician is deceased will allow states to purge the names of deceased physicians from state licensure lists and close this avenue of fraud.

Our data on deceased physicians has also proven to be a valuable tool in uncovering fraudulent credentials of graduates of various Caribbean medical schools. Letters supposedly verifying students' clinical rotations have been uncovered which were allegedly signed by physicians--physicians whom we know to have been deceased either at the time of the fraudulent clerkships or at the time the letters were signed. AMA will continue to look for ways of assisting officials through use of our data. We urge both federal and state investigators to contact us when questions arise about physician credentials.

I also testified before these subcommittees last fall, after introduction of H.R. 5989, the Medicare and Medicaid Patient Protection Act of 1984. That legislation was similar to H.R. 1370 which is now before you. At that time, the AMA voiced strong support for legislation to correct the situations identified by the GAO, where harm to patients or to the Medicare or Medicaid programs could result. We, however, raised several specific concerns regarding the exclusion of individuals from federal health care programs where neither the professional fitness of the physician nor a serious threat to the program was involved and where remedies currently existed. We also were concerned about the adequacy of the procedural due process protections contained in the bill. These and other concerns were expressed also by other witnesses before you last September.

Mr. Chairman, let me make clear our strong support for efforts to end fraud and abuse in federal and state health care programs. Those who intentionally set out to rip-off these programs should be prosecuted to the fullest extent of the law. As I earlier stated, when funds and resources are wasted on fraud and abuse, they become unavailable to provide for covered services. We therefore urge that adequate efforts should be expended for investigation and prosecution.

MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT—H.R. 1370

Loss of Licensure

Mr. Chairman, the AMA continues to support legislation to eliminate participation in Medicare and Medicaid by physicians who lose their license to practice medicine in any jurisdiction for cause related to professional competency. It is important to safeguard beneficiaries from unqualified practitioners.

H.R. 1370 contains improvement over last year's original bill, under which a physician could have been excluded from the programs if a license was suspended or revoked for any reason. We urged that exclusions be applied to those cases where the reasons for revocation or suspension were substantive. H.R. 1370 now would allow exclusion of any individual or entity, "whose license to provide health care has been revoked or suspended by a state licensing authority or who otherwise lost such a license for reasons bearing on the individual's or entity's professional competence, professional conduct, or financial integrity...." This language creates an ambiguity which should be corrected by inserting commas before and after the phrase "or who otherwise lost such a

license." This would clarify that exclusion from the programs would occur only when the revocation or suspension of a state license was for reasons bearing on professional competence, professional conduct or financial integrity.

Minimum Exclusion

The provision in the bill requiring a minimum five-year exclusion upon conviction of a criminal offense related to Medicare should be deleted, in light of the fact that discretionary authority to exclude such individuals is contained also in Section 1128(b)(1). With flexibility to fashion a penalty that fits the offense already available, the mandatory five-year exclusion provision in Section 1128(a) is unnecessary. A mandatory minimum five-year exclusion from health care programs fails to distinguish between various levels of culpability. We believe the Secretary should be allowed to determine the length of exclusion and entertain and be able to give consideration to meritorious requests for reinstatement.

Exclusions for Other Reasons

We also remain concerned that other situations which could result in exclusion under this bill involve neither the professional fitness of the practitioner nor a serious threat to the program involved. For example, the Secretary could exclude from federal health care programs:

- o any entity for failing to grant immediate access to its records and documents;
- o any entity managed by an individual against whom a civil monetary penalty under Section 1128A has been assessed;
- o any individual or entity failing to supply information regarding certain subcontractors and business transactions.

Without diminishing the importance of complying with administrative requirements of federal health care programs, such infractions generally are relatively minor compared to substantive matters, such as loss of a license because of incompetence. We believe that the Secretary already has adequate remedies to address these other deficiencies.

Due Process

Another concern with this legislation involves the inadequacy of provisions for procedural due process. In situations where an action by a state licensing board or a judicial body is the basis for exclusion, reliance on the state board's or court's due process procedures should be adequate. We are concerned with those situations where the exclusion in the bill is based strictly on the Secretary's determination. This legislation should spell out the procedural due process protections afforded to any alleged violator. These fundamental protections are basic to our system of justice and cannot be too strongly emphasized, considering the consequences of an exclusion determination.

Conflict with Peer Review

Proposed Section 1128(b)(5)(C) should be modified. This provision grants the Secretary authority to exclude any individual or entity determined by the Secretary to have furnished items or services in excess of the patient's needs or to be of a substandard quality. Such authority is already available under the PRO law. It is important, we believe, that quality of care determinations remain a function of peer review. In light of the existing authority in this area, we recommend that this provision be deleted from the bill as unnecessary.

Licensure Data Clearinghouse

The AMA concurs with testimony of other witnesses last September that HHS should not become a central clearinghouse for state licensure actions. Reporting of state licensure actions, such as suspensions and revocations, is a function already well performed by others. Any inadequacies in the collection and distribution of state licensure action data should be addressed within the existing system. As we discussed earlier, the AMA is actively involved in disseminating such information.

Injunctive Authority

The bill also contains a provision allowing the Secretary to seek injunctive relief and freeze assets when it appears a person "is about to" commit a violation subject to a civil monetary penalty. There is no requirement that the Secretary must have reason to believe that assets would be removed or concealed before freezing them. This authority is overbroad and should be dropped.

Controlled Substances Registration

We must oppose a companion bill, H.R. 1369, which authorizes the revocation or suspension of a practitioner's registration under the Controlled Substances Act because of certain exclusions from participation in Medicare. A penalty imposed by law should relate to the offense. Withdrawal of a practitioner's controlled substances registration for an offense totally unrelated to controlled substances practices is not appropriate and this bill should not be adopted.

THE MEDICAL IMPOSTORS ACT OF 1985--H.R. 1091

We support provisions which would authorize the Secretary to impose civil penalties and seek criminal sanctions against an individual who

misrepresents himself or herself as a licensed physician. The serious risk of harm to patients from individuals posing as physicians is obvious. It should be observed, however, that current federal statutes provide remedies for this misrepresentation. Indeed, such a misrepresentation is currently subject to sanctions under the statutes sought to be amended.

Another provision of H.R. 1091 applies civil and criminal penalties to an individual who has obtained a license through misrepresentation of material fact or cheating on a licensure examination. We recommend a modification so that such sanctions under Medicare occur after the individual's license has been suspended or revoked by the state licensure authority for misrepresentation or cheating. This modification could be accomplished by changing the pertinent sections of the bill to read: "was licensed as a physician, but such license was suspended or revoked by state authority because the license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing)." This would allow for the proper review of credentials at the state level with the federal government taking action after the state has resolved the case. Such a technical modification in the bill would retain the appropriate state role and not interject an inappropriate federal administrative role in the state licensing process. This amendment would protect federal fiscal interests.

The third category of sanctioned individuals would be those who hold themselves out as board-certified medical specialists when, in fact, they are not so certified. It is not clear what the intent of this provision is and who is intended to be covered. For example, there are 23 medical

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specialty boards, certifying in 29 areas, which are recognized by the American Board of Medical Specialties and the American Medical Association. Other "boards" do not have this recognition and many corporate entities use the words "American Board" as part of their names in the health care area. We are also concerned that there may be a general lack of understanding of the fact that a physician may limit a practice to a "specialty" without being "board certified" and that such a physician may have the same training and skills as a physician who is "certified." We therefore urge careful consideration of this provision in order that undesirable and unintended consequences do not occur. Major clarification in the language is needed.

We note also that criminal penalties would be imposed under the bill on those with knowledge or those having "reason to know" that an individual is not licensed, or is not board certified or obtained a license through misrepresentation. The existing criminal provisions being amended in the Social Security Act require conduct "knowingly" and "willfully" committed. We believe the criminal violation provisions of H.R. 1091 should reflect the same degree of intent.

CONCLUSION

The AMA will continue its efforts to address the problems created when sanctioned practitioners move to other jurisdictions, and we encourage states to fund adequately their medical licensing programs. We support efforts to close the gaps in the Secretary's authority which are discussed by the GAO in its report on physicians whose licenses are revoked for cause. We urge caution against using exclusion from programs

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where other administrative sanctions appropriately remedy any defaults and where patients are not at risk. Finally, we stress the importance of procedural due process for the individuals involved. We support the major thrusts of both H.R. 1370 and H.R. 1091 and we would be pleased to work with the committees to correct the problems with the bills that we have identified.

Mr. Chairman, we commend the Committees for their continuing efforts in this area. The medical profession has always supported efforts to deal with fraud and abuse related to medical practice. Since the enactment of Medicare and Medicaid, the AMA has supported efforts of the federal and state governments to deal with fraud and abuse in these and other health programs. Notwithstanding this strong support, we are compelled to make a cautionary comment. Congress must not so direct enforcement efforts that they become so punitive and harsh that unintentional errors or misunderstanding of program requirements--which are now so complicated--become traps for providers who are trying to meet their obligations to serve patients. The Congress should strive to avoid an atmosphere of fear and instead foster an attitude of cooperation.

We would be pleased to answer any questions the members of the Subcommittees may have.

Mr. STARK. Thank you very much, Dr. Ring.

We'll hear, if we may, from Dr. Rosenberg, and then the committee will direct some questions.

STATEMENT OF ROBERT G. ROSENBERG, M.D.

Dr. ROSENBERG. Mr. Chairman, and subcommittee members, I am Dr. Robert G. Rosenberg, executive director of Group Health Association of Washington, DC, not Group Health Association of America.

Group Health Association is a consumer cooperative HMO of 140,000 members, established in 1937, and is one of the Nation's largest and most experienced group practice health plans.

I also serve on the Executive Committee of Group Health Association of America, the national association of group and staff model HMO's, whose member plans include nearly 75 percent of the national HMO enrollment.

Perhaps most pertinent to this testimony is my current position as president of the National Committee on Quality Assurance. NCQA was formed and established following the enactment of the HMO Act. That act requires HMO's to have formal peer-based quality assurance programs in place, focusing on the entire spectrum of health care services. NCQA is an independent organization of physician peers which provides review of HMO quality assurance systems, to make sure that the systems are in accordance with the intent of Congress and sound medical practice.

Mr. Chairman, I state unequivocally at the outset that we support the underlying intent of H.R. 1370, to protect the Medicare and Medicaid programs and their beneficiaries from fraud and abuse.

In the early 1970's, the legitimate and sound HMO's of this country suffered as a result of scandals under the Prepaid Health Plan Program for Medical beneficiaries in California. We, the HMO's that GHAA represents, were not involved in these scandals, but nonetheless were subjected to undue attacks on our credibility, as well as some fairly stringent regulatory enactments as a result.

My testimony today focuses on section 2 of H.R. 1370, which amends section 1128 and subjects HMO's and other entities who contract under section 1876 (Medicare) or section 1903(m) [Medicaid] to the bill's sanctions and penalties if such entities have "failed in a substantial number of cases to provide medically necessary items and services that are required under law or contract."

We have some concern that this provision appears to ignore the protections and restrictions already built into existing laws and regulations. Such safeguards are found in the HMO Act itself, as well as in title 18 and title 19.

The specific requirements in the above three include granting of contracts; termination of contracts and the maintaining of contracts. In addition, 42 States have HMO enabling legislation, and 37 of those have quality assurance requirements in place.

As you are aware, Mr. Chairman, the regulations implementing the new TEFRA risk contracts under section 1876 were only issued in January of this year. Medicare demonstration projects are currently in the process of being converted to TEFRA risk contracts,

and other HMO's and competitive medical plans [CMP's] are still only in the application stage. It is much too premature to gauge the effectiveness of the safeguards in the regulations. We urge you to allow this new Prospective Payment Program to become operational before attempting to add another statutory and/or regulatory layer of utilization oversight.

Of perhaps greatest significance to this legislation and to these hearings are the ongoing discussions between officials of the Health Standards and Quality Bureau [HSQB] of HCFA, and representatives of the HMO industry, who are currently developing a peer review methodology for HMO's and CMP's under TEFRA contracts.

HSQB has asked for recommendations from the industry by the end of this month, based on nine specific conditions which address both inpatient and ambulatory care and include review of patient records.

Also under consideration are the kinds of sanctions and penalties, including loss of provider status and civil monetary penalties, which might be applied to those organizations which fail to comply with PRO quality objectives. We would be happy to furnish your staff with copies of the parameters proposed by HSQB as well as the industry recommendations.

In light of the fact that HMO's and CMP's with contracts under section 1876 would be subject to PRO review, we question whether this legislative proposal is really necessary at this time. We recommend that the PRO process be implemented before there is a decision that further safeguards are necessary. If it appears that the PRO process is not effective, we would then be happy to cooperate with you in drafting legislation to protect HMO enrollees from unsound medical practices.

We appreciate having had the opportunity to comment on H.R. 1370. Let me reiterate that GHAA endorses the goals of this legislation, and we look forward to working with you to help achieve them.

[The prepared statement of Dr. Rosenberg follows:]

STATEMENT
ON BEHALF OF
GROUP HEALTH ASSOCIATION OF AMERICA, INC.

ROBERT G. ROSENBERG, M.D.
EXECUTIVE DIRECTOR
GROUP HEALTH ASSOCIATION, INC.

Mr. Chairmen and subcommittee members, I am Dr. Robert G. Rosenberg, Executive Director of Group Health Association, Inc. (GHA) of Washington, DC. GHA is a consumer cooperative HMO of 140,000 members established in 1937 and is one of the nation's largest and most experienced group practice health plans. I also serve on the Executive Committee of Group Health Association of America (GHAA), the national association of group and staff model HMOs, whose member plans include nearly 75% of the national HMO enrollment.

Perhaps most pertinent to this testimony is my current position as President of the National Committee on Quality Assurance (NCQA). NCQA was formed and established following the enactment of the HMO Act (PL 93-222.) That act requires HMOs to have formal peer-based quality assurance systems in place, focusing on the entire spectrum of health care services. NCQA is an independent organization of physician peers which provides review of HMO quality assurance systems to make sure that these systems are in accord with the intent of Congress and sound medical practice.

Mr. Chairmen, I state unequivocally at the outset that we support the underlying intent of H.R. 1370 to protect the

Medicare and Medicaid programs and their beneficiaries from fraud and abuse. In the early 1970's, the legitimate and sound HMOs of this country suffered as a result of scandals under the prepaid health plan (PHP) program for MediCal beneficiaries in California. We were not involved in those scandals but nonetheless were subjected to undue attacks on our credibility, as well as some fairly stringent regulatory enactments as a result.

My testimony today focuses on Section 2 of H.R. 1370 which amends Section 1128 and subjects HMOs and other entities who contract under Section 1876 (Medicare) or Section 1903 (m) (Medicaid) to the bill's sanctions and penalties if such entities have "failed in a substantial number of cases to provide medically necessary items and services that are required under law or contract."

We have some concern that this provision appears to ignore the protections and restrictions already built into existing laws and regulations. Such safeguards are found in the HMO Act itself, as well as in Title 18 and Title 19. Among the requirements for federal qualification under the HMO Act are

those which specify that an organization must be fiscally sound and adequately protected against insolvency; provide a grievance procedure; establish an ongoing quality assurance program which stresses health outcomes and provides review by physicians and other health professionals of the delivery of its health services; and disclose information relating to the cost of its operations, utilization patterns, and the availability, accessibility, and acceptability of its service.

With regard to Medicaid, regulations implementing amendments to Section 1903 (m) under the Omnibus Budget Reconciliation Act of 1981 (PL 97-35) provide for certain contract requirements between a Medicaid agency and an HMO, including the inspection and auditing of financial records and termination of enrollment by the Medicaid enrollee. The HMO, however, may not terminate a recipient without state approval. The HMO must establish grievance procedures and have a quality assurance program. The Medicaid agency must approve marketing materials, obtain proof of financial solvency, obtain assurances that appropriate health services have been furnished and establish a system of periodic medical audits. The Health Care Financing Administration (HCFA) may withhold federal funds if

either the State or the HMO substantially fails to carry out the terms of the contract.

Regulations implementing Section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA; PL 97-248) place specific conditions on organizations receiving Medicare risk contracts, including

- o specified benefits and services that must be provided;
- o federal oversight of quality of care and financial viability;
- o enrollment and disenrollment requirements;
- o protection of the rights of individual members, including disenrollment and grievance procedures;
- o acceptable marketing standards and practices;
- o procedures for contract approval and termination (Section 417. 494 (b) of the regulations allows HCFA to terminate a contract for any of the following reasons: if the organization has failed substantially to carry out the terms of the contract, if it is carrying out the contract in a manner that is inconsistent with the effective and efficient implementation of Section 1876, or if the Public Health Service determines that the organization no longer qualifies).

As you are aware, Mr. Chairmen, the regulations implementing the new TEFRA risk contracts under Section 1876 were only issued in January of this year. Medicare Demonstration projects are currently in the process of being converted to TEFRA risk contracts, and other HMOs and Competitive Medical Plans (CMPs) are still only in the application stage. It is much too premature to gauge the

effectiveness of the safeguards in the regulations. We urge you to allow this new prospective payment program to become operational before attempting to add another statutory and/or regulatory layer of utilization oversight.

Of perhaps greatest significance to this legislation and to these hearings are the ongoing discussions between officials of the Health Standards and Quality Bureau (HSQB) of the HCFA and representatives of the HMO industry who are developing a peer review methodology for HMOs and CMPs under TEFRA contracts. A major purpose of these meetings is to assure that the reviews are truly peer reviews and are based on a thorough understanding of the prepaid group practice system. HSQB has asked for recommendations from the industry by the end of this month based on nine specific conditions which address both inpatient and ambulatory care and include review of patient records.

Also under consideration are the kinds of sanctions and penalties, including loss of provider status and civil monetary penalties, which might be applied to those organizations which fail to comply with PRO quality objectives.

We would be happy to furnish your staff with copies of the parameters proposed by HQSB as well as the industry recommendations.

In light of the fact that HMOs and CMPs with contracts under Section 1876 will be subject to PRO review, we question whether this legislative proposal is really necessary at this time. We recommend that the PRO process be implemented before there is a decision that further safeguards are necessary. If it appears that the PRO process is not effective, we would then be happy to cooperate with you in drafting legislation to protect HMO enrollees from unsound medical practices.

We appreciate having had the opportunity to comment on H.R. 1370. Let me reiterate that GHAA endorses the goals of this legislation, and we look forward to working with you to help achieve them.

Mr. STARK. How about if we just do it the other way? You help us draft the bill now; we will pass it; and if it turns out we don't need it later, we will repeal it. Err on the side of caution.

Dr. ROSENBERG. It would certainly be tempting to do that. Being exposed to the regulatory process now, I do believe that we really do have in place sufficient safeguards in all of the jurisdictions.

Mr. WAXMAN. Dr. Rosenberg, you indicated that discussions you are having with HCFA regarding peer review of HMO's is of great significance to this provision. Could you elaborate a little bit on why the discussions are significant for our consideration, and what you expect to be developed from these discussions?

Dr. ROSENBERG. In our discussions with HCFA we have focused on the role of the PRO's and perhaps other entities in doing quality assurance review of all the HMO's and CMP's that will be covered under this contract.

I have been involved in that. I have been aware of the very deep concern that HCFA has over quality assurance and protection of its members. I think we in the industry have responded with enormous alacrity to work with them.

I think that what's going to emerge out of that will be a substantive quality assurance review program that is significant and perhaps unusual in this country in really focusing on peer review-based quality assurance, as well as protecting through a variety of other mechanisms all the members. It is a major movement and one which I think will be very far-reaching.

Mr. WAXMAN. Dr. Ring, in addressing the bill sponsored by Mr. Wyden, H.R. 1091, you indicated some concern about the current drafting of the provisions regarding physicians who misrepresent that they are board-certified in a medical specialty. You indicated that clarification is needed. Can you indicate more specifically what revisions you would suggest?

Dr. RING. Some clarification in the language to make it absolutely clear that the physician is representing himself as something that he is not. A physician without benefit of board certification can specialize in a particular type of illness, disease or field of medicine. In fact, many physicians do.

Many physicians who are internists, board-certified internists, can say, I am a cardiologist. He may not have his boards in cardiology.

Mr. WAXMAN. So you are afraid that the provision would clamp down on a physician who simply says he is specializing in a certain way, even though I think what Mr. Wyden is trying to get to is the representation that he is board certified in that specialty.

Dr. RING. My concern is that there could be misinterpretations on the part of the patient. A doctor who tells a patient yes, I am a cardiologist, or, I am certified and I am a cardiologist—that could be misinterpreted as saying, I am a board-certified cardiologist.

Mr. RUBIN. Mr. Chairman, there is also a concern in the drafting of the legislation—and we would be glad to discuss this further with Mr. Wyden—that the bill may, in fact, establish Federal recognition to these 200 or so other entities that call themselves boards. These entities are subject to no outside scrutiny. They have no outside recognition, as are the 23 boards of the AMA and the American Board of Medical Specialties.

We are concerned that this may give them some amount or type of federal recognition in law and give some credence to their certification which may not be justified.

Mr. WAXMAN. We will want to look at that section with you.

Mr. STARK. Do the certification boards specify in what manner their certification can be used? I mean, realtors make you put a sign up in the window or something and put the copyright symbol on it.

Dr. RING. Some of them do. I am not sure that all of them do.

Mr. WYDEN. Would the gentleman yield on that?

Mr. STARK. Certainly. Go ahead.

Mr. WYDEN. I appreciate the gentleman yielding. I just want to say that the objective, I think, is one we can agree on. That is that there are practitioners in this country who are holding themselves out to be specialists when, in fact, they have not the training for that specialty.

And let's not try to go through it this afternoon, when it's such a complicated, technical kind of area. But I would hope that we could agree on the objective. I gather that you do, from your testimony. Let's just make sure that people are not holding themselves out to be specialists when, in fact, they are not. Do you agree with that?

Dr. RING. I have a question. What of the doctor who chooses to specialize in emergency medicine, and he is not board certified? He holds himself out—he wants to work in a hospital emergency room. Is he defrauding anybody?

Mr. WYDEN. I would only say let him work in an emergency room if he is qualified, but don't let him say that he has this special certification unless, in fact, he has it. Do you agree with that?

Dr. RING. I agree with that. Nobody would ever argue with you that if I stood up and said, I am a board-certified neurosurgeon, I would like to remove your brain tumor, that I ought to be put in jail.

Mr. WYDEN. Great. Can I proceed with another question?

Mr. STARK. Yes, go ahead.

Mr. WYDEN. Just one other quick question.

It seems to me that the problem we are talking about today, incompetent physicians and the phony doctors and the like, is a significant source of the malpractice problem that we are seeing in this country and the malpractice crisis that you all have described many times recently.

Do you agree with that? Do you think this is a significant cause of the malpractice problem we are facing?

Dr. RING. I think it could be. I am not sure that that is the case. I think that is a possibility.

Mr. WYDEN. But all the evidence suggests that the bulk of the malpractice problem comes from a relatively small number of practitioners who are liable for most of the malpractice judgments; isn't that right?

Dr. RING. I saw some horrendous statistics recently that suggested that in some States, next year, one doctor in six is going to be sued. That's not a small number.

Mr. WYDEN. No. I'm talking about who are found liable.

Dr. RING. Found guilty?

Mr. WYDEN. Yes. That doctors who are found guilty and who are responsible for raising the malpractice premiums, are actually a small percentage of all doctors.

Dr. RING. I'm sorry, I don't have those numbers at my fingertips. I recognize the thrust of your argument as a distinct possibility, but I have not seen numbers to verify it.

Mr. WYDEN. My understanding is that that's part of the AMA report on the malpractice problem in America. And I would just hope that that, in and of itself, would be a justification for our passing these two bills, and we appreciate your support because I think getting after the phonies and incompetents can bring us a long way to getting malpractice under control. Those are savings that could be passed on to the consumer.

Dr. RING. We would hope so.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Moore.

Mr. MOORE. I just want to thank Dr. Ring for coming in and testifying as far as he did in support of the bill, H.R. 1370. I understand he has problems with it. We have had those same problems and I'm not sure we have yet worked them out. But in any event, I appreciate the AMA coming forward in support of something like this, as we do hope to receive their support.

Mr. STARK. Mr. Nielson, welcome to the committee.

Mr. NIELSON. Mr. Chairman, I would like to ask unanimous consent that I be allowed to put a statement into the record, inasmuch as I have not yet been assigned to this subcommittee.

Mr. STARK. Without objection.

Mr. NIELSON. I also ask unanimous consent that the the remaining members who might be assigned to this subcommittee be allowed to put statements in the record.

Mr. STARK. Without objection.

Mr. NIELSON. And also, that any responses to questions they may have would also be put into the record.

Mr. STARK. Without objection.

Mr. NIELSON. Thank you. I have no other statement at this time. I appreciate the opportunity of coming.

Mr. STARK. Gentlemen, thank you very much for participating and we look forward to working with you as this legislation progresses.

Our next panel is Barbara Matula, chairperson, State Medicaid Directors Association and Albert Appleton, executive assistant, Office of Deputy Attorney General for Medicaid Fraud, State of New York.

I would like to welcome you to these joint committee hearings and thank you for submitting to our harsh time limits. I would ask if Ms. Matula would proceed to summarize in any fashion you see fit. Please proceed.

STATEMENTS OF BARBARA D. MATULA, CHAIRPERSON, STATE MEDICAID DIRECTORS ASSOCIATION; AND ALBERT F. APPLETON, CHAIRMAN, LEGISLATIVE COMMITTEE, NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

Ms. MATULA. Thank you. I am Barbara Matula, I am director of North Carolina's Medicaid Program, and I am also the chairperson of the State Medicaid Directors Association. Thank you for giving me this opportunity to present the views of the State Medicaid aid agencies.

We believe we work very hard in our States to detect and prevent fraud and abuse and, of course, to help apprehend those who have committed criminal offenses against our program. While we have done a good job in containing abuses, due largely I think to our sophisticated management information systems which help us protect unusual practice patterns among the providers, we can always use a little help. And we believe that H.R. 1370 gives us the tools we need to further minimize the fraud and abuses that do occur.

In general, of course, we are in favor of a nationally consistent enforcement of Medicare and Medicaid sanctions against fraudulent or abusive providers. This is going to be especially useful to those individual State programs that have limited resources and limited access to information from other States regarding providers who have committed criminal offenses.

State Medicaid agencies support the bill's exclusion provisions completely. The broadening of the Secretary's authority regarding conditions under which the providers can be excluded is long overdue. We are especially pleased that the bill would grant States the same authority as the Secretary to exclude providers from the Medicaid Program.

I would suggest that the subcommittee consider strengthening the enforcement provision by granting the Secretary and the States the authority to immediately exclude any provider whose behavior poses a significant risk to the health and safety of Medicaid recipients. Waiting for established administrative procedures to run their course could jeopardize recipients' well-being in some situations.

We do support, of course, the bill's requirement that providers be excluded from both Medicare and Medicaid if they had been excluded from the Medicaid Program in any one State. We favor the 5-year mandatory exclusion requirement as a reasonable and a just penalty for any provider who has been convicted of the offenses listed in the bill.

And we also support the provision permitting a limited exclusion of providers that failed to grant the State's immediate access to their records in the normal conduct of their business.

The bill does allow us to seek a waiver of any required exclusion by the Secretary. This would prove very useful to us. We had an individual case in North Carolina where this happened last year where a provider to be excluded from our program would have left that community without a pharmacist to meet any of their needs, especially the Medicaid recipients.

So we would prefer instead that we be allowed exceptions, and we could take some alternative punitive action rather than total exclusion, so we're happy that that's in there.

We, of course, support the clearinghouse and information network. We would caution that safeguards be used in confidentiality matter, and in general—well, not surprisingly. I'm sure you will note that the State Medicaid agencies support the provision that increases the amount of funds that States can keep from the recoupments.

So thank you again for letting me present our views, and I actually beat the light.

[The prepared statement of Ms. Matula follows:]

TESTIMONY OF
BARBARA D. MATULA
CHAIRPERSON, STATE MEDICAID DIRECTORS' ASSOCIATION
OF THE
AMERICAN PUBLIC WELFARE ASSOCIATION
AND
DIRECTOR, NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

GOOD AFTERNOON, MR. CHAIRMAN. I AM BARBARA D. MATULA, DIRECTOR OF THE NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE AND CURRENT CHAIRPERSON OF THE STATE MEDICAID DIRECTORS' ASSOCIATION OF THE AMERICAN PUBLIC WELFARE ASSOCIATION. I AM HERE TODAY TO PRESENT THE VIEWS OF THE STATE MEDICAID DIRECTORS CONCERNING THE "MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1985" (H.R. 1370).

LET ME PREFACE MY REMARKS ON H.R. 1370 WITH A FEW GENERAL COMMENTS REGARDING FRAUD AND ABUSE IN THE MEDICAID PROGRAM. THE STATE MEDICAID AGENCIES ARE CONCERNED ABOUT FRAUD AND ABUSE AND WORK HARD TO PREVENT IT AS WELL AS APPREHEND THOSE WHO HAVE COMMITTED CRIMINAL OFFENSES AGAINST THE PROGRAM. WE BELIEVE WE CURRENTLY DO A GOOD JOB OF PREVENTING ABUSE, DUE IN LARGE PART TO THE USE OF SOPHISTICATED MANAGEMENT SYSTEMS WHICH HELP US DETECT PROBLEMS AMONG THE PROVIDERS IN OUR PROGRAM BEFORE THEY BECOME CASES OF FRAUD.

BUT WITH A PROGRAM THE SIZE AND COMPLEXITY OF MEDICAID, THERE ARE ALWAYS NEW WAYS TO FURTHER MINIMIZE THE FRAUD AND ABUSE THAT DO OCCUR. I COME HERE TODAY TO VOICE THE STATE MEDICAID DIRECTORS' SUPPORT FOR H.R. 1370, BECAUSE IT GOES A LONG WAY TOWARDS INCREASING OUR ABILITY TO BOTH PREVENT FRAUD AND ABUSE AND KEEP UNDESIRABLE PROVIDERS OUT OF THE MEDICAID PROGRAM. IN GENERAL, THE BILL WOULD FOSTER NATIONALLY CONSISTENT ENFORCEMENT OF MEDICARE AND MEDICAID SANCTIONS AGAINST FRAUDULENT OR ABUSIVE PROVIDERS. THIS WOULD BE A DESIRABLE IMPROVEMENT IN INDIVIDUAL STATE PROGRAMS THAT HAVE LIMITED RESOURCES AND LIMITED ACCESS TO INFORMATION FROM OTHER STATES REGARDING PROVIDERS WHO HAVE COMMITTED CRIMINAL OFFENSES.

WITH REGARD TO THE BILL'S EXCLUSION PROVISIONS, THE STATE MEDICAID AGENCIES ARE IN COMPLETE SUPPORT OF H.R. 1370. THE BROADENING OF THE SECRETARY'S AUTHORITY REGARDING CONDITIONS UNDER WHICH PROVIDERS CAN BE EXCLUDED FROM MEDICARE AND MEDICAID IS LONG OVERDUE. WE ARE PARTICULARLY PLEASED WITH THE BILL'S PROVISION WHICH WOULD GRANT THE STATES THE SAME AUTHORITY AS THE SECRETARY TO EXCLUDE PROVIDERS FROM THEIR MEDICAID PROGRAMS. THIS EXTENSION OF AUTHORITY WILL HELP SIGNIFICANTLY IN DEALING WITH THE UNDESIRABLE PROVIDERS IN OUR PROGRAM.

I WOULD ALSO SUGGEST THAT THE SUBCOMMITTEE CONSIDER STRENGTHENING THE ENFORCEMENT PROVISION BY GRANTING THE SECRETARY AND THE STATES THE AUTHORITY TO IMMEDIATELY EXCLUDE ANY PROVIDER WHOSE BEHAVIOR POSES A SIGNIFICANT RISK TO THE HEALTH AND SAFETY OF MEDICAID RECIPIENTS. WAITING FOR THE ESTABLISHED ADMINISTRATIVE PROCEDURES TO RUN THEIR COURSE WOULD JEOPARDIZE RECIPIENTS' WELL-BEING.

WE SUPPORT THE BILL'S REQUIREMENT THAT PROVIDERS BE EXCLUDED FROM BOTH MEDICARE AND MEDICAID, IF THEY HAVE BEEN EXCLUDED FROM THE MEDICAID PROGRAM IN ONE STATE. IN PARTICULAR, WE SUPPORT THE PROVISION THAT, IF A PROVIDER LOSES HIS LICENSE IN ONE STATE, HE WOULD BE EXCLUDED FROM THE MEDICARE AND MEDICAID PROGRAMS ENTIRELY. THE GENERAL APPLICATION OF PENALTIES WOULD BOTH STRENGTHEN PROGRAM ENFORCEMENT AND BRING ABOUT FURTHER CONSISTENCY IN THE PROGRAM'S ANTI-FRAUD AND -ABUSE POLICY.

THE FIVE YEAR MANDATORY EXCLUSION REQUIREMENT IN THE BILL IS A PROVISION WE ALSO FAVOR. THIS IS A REASONABLE AND JUST PENALTY FOR ANY PROVIDER WHO HAS

BEEN CONVICTED OF THE OFFENSES LISTED IN THE BILL. SUCH A CLEAR AND DECISIVE PENALTY CAN ONLY HELP PREVENTION EFFORTS. IN ADDITION, THE STATE MEDICAID AGENCIES BELIEVE THAT THE PROVISION PERMITTING THE EXCLUSION FOR A LIMITED TIME OF PROVIDERS THAT FAIL TO GRANT THE STATES IMMEDIATE ACCESS TO THE PROVIDERS' RECORDS IN THE NORMAL CONDUCT OF STATE BUSINESS, WOULD BE A PARTICULARLY USEFUL TOOL IN PRESERVING PROGRAM INTEGRITY.

THE BILL DOES, HOWEVER, ALLOW STATES MEDICAID AGENCIES TO SEEK A WAIVER OF ANY REQUIRED EXCLUSION BY THE SECRETARY. THIS IS A VALUABLE PROVISION. MUCH AS WE ABHORE THE CRIMINAL AND UNETHICAL ACTIVITIES OF CERTAIN PROVIDERS, THE FACT IS THAT IN MANY AREAS OF THE COUNTRY THE NUMBER OF PROVIDERS PARTICIPATING IN THE PROGRAM IS LIMITED. TOTAL EXCLUSION OF A MEDICAID PROVIDER IN AN AREA THAT HAS NO OTHER PROVIDERS COULD BE COUNTER PRODUCTIVE AND CONTRARY TO THE PROGRAM'S INTENT OF ENSURING ACCESS TO CARE FOR THOSE IN NEED. WE BELIEVE SUCH EXCEPTIONS SHOULD BE ALLOWED, WITH THE STATE TAKING SOME ALTERNATIVE PUNITIVE ACTION AGAINST THE PROVIDER OTHER THAN TOTAL EXCLUSION.

THE PROVISIONS IN THE BILL WHICH, IN EFFECT, SET UP AN INFORMATION NETWORK ON EXCLUDED PROVIDERS WILL BE USEFUL TO THE STATES AND OBVIOUSLY ARE ESSENTIAL FOR THE IMPLEMENTATION OF THE PROPOSED EXCLUSION. WE BELIEVE HAVING HHS NOTIFYING STATES OF EXCLUSIONS OF PROVIDERS IN MEDICARE AND REQUESTING STATES TO TAKE ACTION IS ENTIRELY APPROPRIATE. WE ALSO AGREE WITH THE REQUIREMENT THAT STATES HAVE A REPORTING SYSTEM TO NOTIFY HHS OF ANY ADVERSE DECISION BROUGHT AGAINST A PROVIDER AT THE CONCLUSION OF A FORMAL PROCEEDINGS OR WHEN A LICENSE IS SURRENDERED AS A RESULT OF THE PROCEEDING. I WOULD LIKE TO NOTE THAT THIS PARTICULAR PROVISION IS AN IMPROVEMENT FROM A SIMILAR PROVISION IN

LAST YEAR'S BILL, WHICH WOULD HAVE REQUIRED REPORTING TO HHS AT THE COMMENCEMENT OF FORMAL PROCEEDINGS. THE LATTER REQUIREMENT WOULD HAVE PLACED AN UNNECESSARY BURDEN ON THE STATES AND, BECAUSE OF THE VOLUME OF INFORMATION INVOLVED, WOULD HAVE IMPEDED, RATHER THAN HELPED, FEDERAL/STATE EFFORTS. THE PROVISION IN THE CURRENT BILL WILL PROVIDE MORE RELEVANT INFORMATION AND PROVE MORE EFFECTIVE IN COMBATING FRAUD AND ABUSE.

THE STATES ALSO SUPPORT HHS ACTING AS A CLEARINGHOUSE OF INFORMATION REPORTED BY THE STATES TO BE DISPERSED TO STATE AGENCIES AND PEER REVIEW ORGANIZATIONS (PROs). WE WISH TO STRESS THE IMPORTANCE, HOWEVER, OF PROVIDING SAFEGUARDS FOR THE CONFIDENTIALITY OF THIS INFORMATION. WHILE THE DISTRIBUTION OF INFORMATION TO THE RELEVANT STATES AND ENTITIES IS NECESSARY, MISUSE OF SUCH INFORMATION COULD LEAD TO THE UNDERMINING OF THE GENERAL EFFORT.

NOT SURPRISINGLY, THE STATE MEDICAID AGENCIES AGREE WITH THE BILL'S PROVISION TO INCREASE THE AMOUNT OF FUNDS COLLECTED BY THE STATES THROUGH CIVIL MONETARY PENALTIES. CURRENTLY, THE FEDERAL GOVERNMENT INSISTS ON RECOVERING ALL OF ITS SHARE OF FUNDS BEFORE DISPERSING FUNDS TO THE STATES. THE STATES BELIEVE THAT THE PROPOSED PROVISION WOULD PROVIDE AN EQUITABLE SOLUTION TO AN INEQUITABLE SITUATION.

THANK YOU FOR LETTING ME PRESENT THE STATE MEDICAID AGENCIES' VIEW ON THIS EXCELLENT BILL. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Mr. STARK. You have set a record for today's hearing. Mr. Appleton, would you like to introduce the person accompanying you?

STATEMENT OF ALBERT F. APPLETON

Mr. APPLETON. Thank you, Mr. Chairman. I am accompanied by Ms. Barbara Zelner, who is counsel for the National Association of Medicaid Fraud Control Units. I am Albert Appleton, I'm an executive assistant attorney general in the New York State Office of Medicaid Fraud Control, and I also serve as legislative chairman for the National Association of Medicaid Fraud Control Units.

The national association consists of all 36 State Medicaid fraud control units that are established under congressional legislation to prosecute and deter fraud and patient abuse in the Medicaid Program. Units are organized according to Federal guidelines and, if certified, receive partial Federal reimbursement.

Since the establishment of this program, the units have obtained over 2,000 convictions of providers and related parties for fraudulent conduct and patient abuse in the provision of Medicaid services. We feel that these convictions have identified hundreds of potential candidates for exclusion from participation in the Medicaid and Medicare Programs.

The association has long believed that strong participation sanctions are necessary and would add a considerable impact to the deterrent effect of the broad control on other administrative programs. We believe that white collar crime is an area in which the gains and losses of deterrents do work. We believe that Medicaid providers knew that criminal conduct meant an automatic, nationwide exclusion from the program, it would significantly improve compliance with Federal and State legal and administrative standards.

Our members, I might add, are well aware of the importance of excluding such providers from the Medicaid Program. We regularly refer convicted providers to State administrative agencies for decertification and de-licensing. For those reasons, we enthusiastically support this bill, and I might add we endorse its particular provisions.

We are particularly pleased to note that this committee has adopted our recommendations of last year to close the loophole with respect to crimes relating to the obstruction of justice in Medicaid investigations and to add the denial of access by Medicaid fraud control units to required legal information to the grounds for exclusion from Medicaid and Medicare participation.

I would also mention that we endorse the provisions for changing the civil monetary penalties law. They are desirable technical changes.

Before I would close, I would make one point for this committee's consideration. While this legislation is important, it will be only as effective as the resources and effort devoted to its enforcement.

Our units in the past have experienced considerable individual and collective dissatisfaction with the results of our referrals for decertification and delicensing. We now perceive a growing interest, particularly in State licensing agencies where we think the problems have been worse, in improving the situation. But im-

provement will only come if efforts like this hearing continue to focus public attention on the need for reforms like the ones you are now considering.

Moreover, I think you have to be aware that effective legislation is a labor-intensive activity. We have achieved the successes we have in the Medicaid Fraud Control Unit Program because your committees, 8 years ago, established a formula whereby we were guaranteed adequate resources to do our enforcement job.

If you hope to realize your expectations for this statute you will have to, at the appropriate point, take similar action with respect to the resources devoted to its enforcement.

I would like to thank your committees for their efforts in promoting this legislation and for offering us the opportunity to testify.

[Mr. Appleton's prepared statement follows:]

ALBERT F. APPLETON
EXECUTIVE ASSISTANT ATTORNEY GENERAL IN THE
NEW YORK STATE OFFICE OF MEDICAID FRAUD CONTROL
CHAIRMAN - LEGISLATIVE COMMITTEE
NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

MR CHAIRMAN, distinguished members of the Congress, I am Albert F. Appleton, Executive Assistant Attorney General in the New York State Office of Deputy Attorney General for Medicaid Fraud Control, headed by New York State Deputy Attorney General Edward J. Kuriansky. As Chairman of the Legislative Committee of the National Association of Medicaid Fraud Control Units, I am pleased to be here this afternoon to present the views of the Association on H.R. 1370, the Medicare and Medicaid Patient and Program Protection Act of 1985.

The National Association of Medicaid Fraud Control Units is composed of all 36 state Medicaid Fraud Control Units. The Medicaid Fraud Control Unit program was established by Congress in 1977, to deal with the ongoing problem of prosecuting and deterring provider fraud and patient abuse in the Medicaid program. State Fraud Units are organized according to federal guidelines and, if federally certified, receive partial federal reimbursement for their costs.

p. 2, MEDICAID FRAUD CONTROL UNITS ASSOCIATION,

Since the establishment of the program, the Units have obtained almost 2,000 convictions of providers and related parties for fraudulent conduct or patient abuse in the provision of Medicaid services. These convictions have also resulted in the recovery of millions of dollars of Medicaid overpayments for federal, state and local government and the deterrence of many millions more in fraudulent or unnecessary expenditures. These convictions have also identified many hundreds of individuals whose conduct clearly marks them as unfit to participate in any program of publicly supported provision of health care services.

The Association has long believed that strong participation sanctions would add considerable bang to the federal buck, not to mention the state and local funds that are currently being committed to fraud control. Participation in governmentally supported health care programs is one of the most important considerations for providers under investigation. White collar crime is an area where the traditional costs and gains of deterrence actually do work. We believe that if providers knew that a criminal conviction automatically meant exclusion from the program not only in their own state but also throughout the country it would measurably add to the deterrent effect of the fraud unit program.

p.3, MEDICAID FRAUD CONTROL UNITS ASSOCIATION

Our members are well aware of the importance of excluding unsuitable providers from the Medicaid program and regularly refer providers we have convicted for decertification and delicensing proceedings. For that reason, we enthusiastically support the objectives of this act in giving the Secretary power to impose a nationwide exclusion from Title XVIII on providers convicted of defrauding state or federal health care programs. We believe that its specific provisions are carefully drafted and targeted on that objective. We note with particular pleasure that our recommendations with respect to last years legislation, that the grounds for exclusion be expanded to include both crimes relating to obstruction of justice in a Medicaid investigation and the failure to provide required information to a Medicaid Fraud Control Unit, have now been incorporated into the current 1985 bill. We believe their inclusion will strengthen the bill and the Medicaid Fraud Control Unit program.

We now unreservedly urge the passage of this legislation. At the same time, we believe it appropriate to remind you that enforcement of these new requirements will not happen automatically. Without proper implementation and enforcement, passage of this bill will be a meaningless exercise.

p. 4, MEDICAID FRAUD CONTROL UNITS ASSOCIATION,

I am sure we are all aware of the general dissatisfaction with the performance of the agencies that license medical personnel and that certify providers to participate in government sponsored health care programs. Our member units have individually and collectively experienced periodic frustration at the slow pace at which licensing agencies in particular have acted on the referrals we have made to them.

We now perceive a widespread interest in the state licensing agencies we deal with in improving their performance. We believe this is, at least in part, a direct result of the current attention this Congress and others are focusing on them. We urge this Congress and others to maintain that focus. This is a moment that must be seized if we are to create a new set of institutional attitudes and expectations.

At the same time, your Committees, political and health leaders in general, and the public must honestly acknowledge that their desire for improved administration of licensing and certification of medical providers will require meaningful resource commitments. Effective regulation is a labor intensive activity. All are aware of the deficit crisis currently facing the federal government. All are aware of the many competing priorities on the state level for the public dollar.

p. 5, MEDICAID FRAUD CONTROL UNIT ASSOCIATIONS,

Nevertheless, if this statute is to be effective, your committees must not only see the bills through to passage, they must also insist on adequate resources for their implementation. Enforcement has always been the neglected stepchild when it comes to allocating funds to public welfare programs. The Medicaid Fraud Control Unit program owes its success to the foresight of your committees eight years ago in insuring that it would be adequately funded. You must exercise similar leadership as to resource provision if this statute is to satisfy your expectations.

As to the remainder of the bill, we support the provisions strengthening the Civil Monetary Penalties Act. We believe the Civil Monetary Penalties program is an important initiative that fills in the gap between existing systems of state administrative review and the Fraud Control Unit program. We commend the Inspector General and your committees for leadership in this matter.

We would be happy to provide your committees with further information, if it would be useful to you, and we appreciate the opportunity you have extended to use to participate in the drafting of this legislation.

Mr. STARK. Thank you both very much.

We are faced with a bit of a time constraint here. What I am going to suggest is, with the concurrence of the committee, is that we ask Senator Heinz to testify for the next 5 or 6 minutes, at which time the committee will have to recess to vote. We will be gone for about 20 minutes, and we will then take the final panel. And if Ms. Matula and Mr. Appleton could wait, there may be some questions, and we would inquire of you at the time that we question the final panel.

If that will fit in with everybody's schedule. Mr. Waxman.

Mr. WAXMAN. I had some final questions, but I will be happy to submit them for the record, and maybe other members could do that as well, rather than ask this group to stay.

[The following letters were received for the record:]

Congress of the United States
House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, D.C. 20515

March 26, 1985

Albert F. Appleton
Executive Assistant
Office of Deputy Attorney General for Medicaid Fraud
State of New York
270 Broadway, 17th Floor
New York, NY 10007

Dear Mr. Appleton:

Thank you for your testimony Tuesday on H.R. 1370, the Medicare and Medicaid Patient and Program Protection Act of 1985, and for agreeing to answer additional questions for the record. I would appreciate receiving your response to the following questions by Wednesday, April 3.

- 1.) You testified that, since the establishment of the Medicaid State Fraud Control Units, almost 2,000 convictions of providers and related parties have been obtained, resulting in the recovery of millions of Federal and State payments. Do you have any other data that might assist the Subcommittee in getting a sense of the extent or provider fraud and abuse in the Medicaid program?
- 2.) The State Medicaid Directors Association recommended that the Congress grant the States the authority to exclude immediately any provider whose behavior poses a significant risk to the health and safety of Medicaid beneficiaries. H.R. 1370 now provides for a delay of 30 days in the effective date of an exclusion in the case of a patient who is in a hospital or a nursing home or who is under a plan of care for home health or hospice services. The concern here is obviously that services not be interrupted abruptly, to the detriment of the patient. What is your organization's view on this issue? If you agree with the Medicaid Directors' recommendation,
 - a.) What would you recommend with respect to the length of the exclusion in such cases?
 - b.) What due process protections should providers receive in such cases?
 - c.) How would beneficiaries be protected from abrupt interruption of services in such cases?

I look forward to your response. If you have any questions regarding this inquiry, please don't hesitate to contact Andy Schneider of my staff at (202) 225-4952.

With all best wishes, I am

HENRY A. WAXMAN
Chairman, Subcommittee on
Health and the Environment

HAW/asj

cc: Honorable Edward R. Madigan
Honorable Fortney H. Stark



STATE OF NEW YORK
 DEPUTY ATTORNEY GENERAL
 FOR MEDICAID FRAUD CONTROL
 270 BROADWAY, NEW YORK, N. Y. 10007
 (212) 587-5252

EDWARD J. KURIANSKY
 Deputy Attorney General

ALBERT F. APPLETON
 Executive Assistant

April 3, 1985

Hon. Henry A. Waxman
 Chairman, Subcommittee on
 Health and the Environment
 Congress of the United States
 House of Representatives
 Committee on Energy & Commerce
 Room 2125, Rayburn House Office Building
 Washington, D.C. 20515

Dear Congressman Waxman:

Thank you for your letter of March 26, 1985. On behalf of the Medicaid Fraud Unit Association, I will be happy to try to answer your questions.

You first asked if the Fraud Units have any data that might assist the Subcommittee in getting a sense of the extent of provider fraud and abuse in the Medicaid program. I limit this answer to the question of provider fraud as an attempt to characterize the extent of provider abuse depends on what specific practices are described as abusive.

As to provider fraud, the Association has never succeeded in identifying any reliable numerical estimates of the extent of fraud. Moreover, we have grave doubts that any reliable estimates exist. Most attempts to put a statistical range on fraud are anecdotal and are often advanced to serve secondary argumentative purposes. Moreover, the level of fraud at any one time probably directly correlates to perceptions in the provider community as to the level of risk from enforcement activity, and is affected by many other factors. It would take a major research investment to reliably quantify the extent of Medicaid fraud. The Federal Government has never been willing to make that research investment.

We are, however, satisfied that Medicaid fraud represents a meaningful level of financial loss and that fraud in the Medicaid program cannot be dismissed as an isolated phenomenon.

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Hon. Henry A. Waxman

April 3, 1985

We base this conclusion on follow-up studies of particular industry segments where Fraud Units have had investigative activity. For example, in 1983, the New York State Medicaid Fraud Control Office conducted a major investigation in western New York State of ambulance companies providing transportation of Medicaid recipients to and from medical treatment. This investigation resulted in a series of indictments in Buffalo, Rochester and Syracuse for theft from the Medicaid program cumulatively totaling nearly a quarter of a million dollars. Shortly thereafter, a before and after comparison of the Medicaid billings of all Medicaid transportation providers in western New York cities was carried out. Billings from virtually all providers, not just those indicted, showed significant decreases, in some instances approaching 25%.

You have also asked our views on the recommendation the State Medicaid Directors Association that Congress grant the States authority to exclude immediately any provider who poses a risk to the health and safety of Medicaid beneficiaries. We agree with this recommendation. We would reject the proposed thirty (30) day exclusion.

We believe an immediate threat to health and safety is a more imperative concern than transfer trauma. While transfer trauma is a serious concern, we believe the States could readily establish measures to alleviate it. Moreover, as a practical matter, it would be an unusual situation in which State regulators had no notice that a health and safety problem was emerging that might require an immediate emergency exclusion. State administrative agencies should also be able to develop a standard contingency procedure well in advance of any actual emergency.

At the end of the thirty days, the transfer disruption problem will have to be faced anyway. We do not believe thirty days must be lost before dealing with it.

With respect to the duration of the exclusion in such cases, it is difficult for us to see any argument that would permit a provider who had wilfully endangered the health and safety of Medicaid beneficiaries to be readmitted to the program.

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Hon. Henry A. Waxman

April 3, 1985

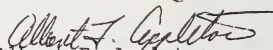
In any event, we think the length of exclusion is less important than the standards that would be applied in judging any application to have such an exclusion ended.

As for due process protections, it is our belief that a hearing initiated within sixty (60) days of the exclusion, conducted under the normal rules of administrative procedure and including appeal to the courts, would be fair. Your Committee should keep in mind that under the current conditions of a widely perceived shortage of nursing home beds it is unlikely that State Medicaid Administrators would act precipitously or arbitrarily in exercising this power.

We hope these answers will be helpful to your Committee. Please don't hesitate to contact us if you need further information.

Let me thank you once again for offering the Association the opportunity to express our views on the Medicare and Medicaid Patient Protection Act, HR 1370. We look forward to speedy action on this badly needed legislation from your Committee and from the Congress.

Very truly yours,


Albert F. Appleton
Executive Assistant

Chairman
Legislative Committee,
National Association of
Medicaid Fraud Control Units

AFA/mlk

Congress of the United States
House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, D.C. 20515

March 26, 1985

Barbara D. Matula, Chairperson
State Medicaid Directors Association
1125 15th Street, N.W.
Suite 300
Washington, D.C. 20005

Dear Ms. Matula:

Thank you for your testimony Tuesday on H.R. 1370, the Medicare and Medicaid Patient and Program Protection Act of 1985, and for agreeing to respond to some additional inquiries for the record. I would appreciate receiving your responses to the following by Wednesday, April 3.

- 1.) H.R. 1370 now provides for a delay of 30 days in the effective date of an exclusion in the case of a patient who is in a hospital or a nursing home or who is under a plan of care for home health or hospice services. The concern here is obviously that services not be interrupted abruptly, to the detriment of the patient.

In your testimony, you recommended that the Congress grant the Secretary and the States the authority to exclude immediately any provider whose behavior poses a significant risk to the health and safety of Medicaid beneficiaries. In this connection,

- a.) How significant is this problem? Do you have any estimates as to the frequency of such provider behavior?
- b.) What is current State practice with respect to such providers, and what are its shortcomings?
- c.) Should the States and the Secretary be given discretion, to be exercised on a case-by-case basis, to terminate services sooner than 30 days if it appears that the harm of continuing services from the current provider would exceed the harm of transferring to a new provider?
- d.) How long a period of exclusion would you recommend in such cases?
- e.) What due process protections would you suggest for the providers?

2.) With regard to the provisions for waiver of exclusion, you testified that in North Carolina this allowed you to keep a sole community pharmacist in the program in order to preserve some access to services for Medicaid patients.

a.) What "alternative punitive actions" do the States have at their disposal for such cases?

b.) What would your view be of a requirement that a State, in order to receive such waiver, impose an alternative punishment acceptable to the Secretary?

I look forward to your responses. If you have any questions regarding this request, please do not hesitate to contact Andy Schneider of my staff at 225-4952.

With all best wishes, I am

Sincerely,

HENRY A. WAXMAN,
Chairman, Subcommittee on
Health and the Environment

HAW/asj

cc: Honorable Edward R. Madigan
Honorable Fortney H. Stark

THE STATE MEDICAID DIRECTORS ASSOCIATION

OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

1125 FIFTEENTH STREET, N.W. WASHINGTON, D.C. 20005

Suite 300

Telephone: (202) 293-7550

April 12, 1985

Henry A. Waxman, Chairman
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives
2415 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Waxman:

I am writing to respond to your letter of March 26, which asked me some questions as follow up to my testimony on the Medicare and Medicaid Patient and Program Protection Act of 1985.

Regarding your first question on the issue of immediately excluding providers who pose a significant risk to the health and safety of Medicaid beneficiaries, I believe I need to clarify my comments. When I referred to this issue I was speaking of non-institutional providers (e.g. physicians, pharmacists) and not institutional providers. For the institutional provider a delay of 30 days in the effective date of an exclusion is appropriate. I believe, however, that the authority to immediately exclude non-institutional providers would be a useful tool for the Secretary and states alike. I should also point out that such authority is only necessary in cases where quality of care is in question, not for administrative violations.

Let me explain what the current practice is for excluding non-institutional providers in North Carolina, and I believe it is similar to other state practices. The state first becomes aware of a problem with a specific provider either through the surveillance and utilization review system (SURS), or from direct complaints. It then takes the state some time to investigate and to establish the reasonable grounds for bringing action against the provider. Medical consultants for the state help conduct this initial review. In North Carolina, once reasonable grounds for an exclusion are established we convene a peer review board of providers in the same field as the provider in question. This board reviews the evidence and makes a judgement. This constitute the administrative appeals process. If adverse, the board's decision can then be appealed by the provider to a court of law.

Because the peer review board can take up to months to complete its work, the current system allows providers to continue participation in the program long after the state agency is aware a quality of care problem may exist. I would suggest that the states be given the authority to temporarily exclude providers before they go to a peer review board, after the state has established reasonable grounds for bringing action against the provider. A temporary exclusion until a more permanent administrative action can be brought, would allow states to bring immediate protection to Medicaid recipients at risk.

Henry A. Waxman
April 12, 1985
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Finally, in answer to your question regarding the frequency of provider behavior that would require such action, aside from saying it is rare, I cannot provide you with specific numbers. With more time I could provide you a more concrete answer.

Your second question was on the issue of excluding sole community providers. Alternative punitive actions states currently can take are recouping funds from the provider, placing the provider under continuous monitoring and instituting prior authorization for recipients' use of that provider. Adverse publicity also acts as an indirect punishment. In addition, some states can impose fines, depending on whether their legislature has granted the Medicaid agency such authority. Your subcommittee might consider granting all states the authority to fine in these cases.

Finally, we believe it is reasonable to require states to take some action against these providers if the state applies for a waiver of exclusion.

Sincerely,

A handwritten signature in cursive script that reads "Barbara D. Matula".

Barbara D. Matula, Chair
State Medicaid Directors' Association
and
Director North Carolina Division of Medical Assistance

Mr. MOORE. I don't have any questions. I just want to thank the two witnesses for giving us their support. It's their kind of constituents that we're trying to help with this bill, and I appreciate your seeing that.

Mr. NIELSON. I have one question for Ms. Matula, and I will be happy to submit it in writing.

Mr. STARK. Thank you. Then the witnesses are excused, and we would ask Senator Heinz, whose prepared testimony will appear in the record in its entirety, to come forward.

We welcome you to the committee and we will let you proceed in any fashion you choose.

STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator HEINZ. Congressman Waxman, Congressman Stark, thank you very much. Let me summarize my testimony by saying that none of us in this room are any strangers to this issue of unfit doctors. Since I last appeared on this side of the Capitol, I have discovered that one of the doctors in the study who I will call Doctor X, lost his license in three States for illegal drug sales. He is now currently licensed to practice in my own State of Pennsylvania, and has been issued a Medicare provider number there.

I suppose the question, Mr. Chairman, that I pose to you is: how can we insure quality care when the very department, Health and Human Services, which is charged with administering the Medicare and Medicaid Programs, lacks the authority to exclude on a national basis doctors found guilty in one State, or by one Federal program, of wrongful acts.

I will be introducing next week a bill that parallels in many respects what you have over here, H.R. 1370 and H.R. 1369. But there are a couple of differences. I will take 60 seconds to point them out.

First, my bill specifies five offenses including unlawful prescribing or dispensing of a controlled substance and neglect or abuse of a patient, for which the Secretary is required to exclude a practitioner from Federal programs. H.R. 1370, as I understand it, leaves the decision to exclude or not to exclude in these cases to the discretion of the Secretary. My rationale in requiring Federal exclusion for these criminal offenses is that they pose a deadly threat to both the health and safety of the patients, as well as to the fiscal integrity of the programs.

I might add that those five offenses, Mr. Chairman, are at least as serious as those for which the Secretary is currently required to exclude.

The second difference in my bill is that it includes the provisions of H.R. 1369, as I understand that bill. I do urge you, if you're going to have action, to combine the sanction regarding the Controlled Substances Act. Over one-third of the practitioners cited in the GAO report were involved in illegal drug sales or drug trafficking. An attorney general armed with the authority to revoke a drug license from any practitioner excluded from the medicare program is an attorney general equipped to protect other innocent citizens from these unscrupulous quacks.

Mr. Chairman, I think our time is about up here. But I just want to commend you, Congressman Stark, and you, Congressman Waxman, the members of your committees and Mr. Moore, Mr. Nielson, Ron Wyden, and others for your interest and your dedication to this problem. We wish you well, we urge your prompt and speedy action.

[The prepared statement of Senator Heinz follows:]

TESTIMONY OF SENATOR JOHN HEINZ

Chairman Stark, Chairman Waxman, members of the subcommittees, thank you for the opportunity to appear before you today. As a former Member of the House, it is my distinct pleasure to once again testify on a most critical issue—the need for legislation to protect 50 million elderly and poor Americans on Medicaid and Medicare from treatment by incompetent and dangerous medical practitioners.

Mr. Chairman, as you are aware, last May I chaired an investigative hearing of the Senate Special Committee on Aging to look into the problem of unfit doctors. A General Accounting Office report released at that hearing showed that doctors who had been banned from practice in one State for criminal acts such as drug trafficking, for sexual or immoral conduct, and for gross incompetence, simply packed up their black bags and moved across State lines to set up practice. One of the doctors in the study, whom I'll call Dr. X, had lost his license in three States for illegal drug sales, yet is currently licensed to practice in my own state of Pennsylvania and has been issued a Medicare provider number there.

The most alarming finding of the GAO report is that Dr. X is not an anomaly—in fact, over one-third of the practitioners in the report held licenses in other States, and many continued to treat patients after having been sanctioned.

Dr. X and his cohorts continue to profit under Federal programs because the Secretary of the Department of Health and Human Services is powerless to prevent their State hopping and program switching. Mr. Chairman, how can we assure quality care when the very department charged with administering these programs lacks the authority to exclude, on a national basis, doctors found guilty in one State, or by one Federal program, of wrongful acts?

The problem is compounded by the very difficulty involved in tracking these unfit doctors from State to State. If Dr. X had lost his driver's license for drunk driving, his name would go into a national registry and he would be denied a driver's license in every other State. Yet we have no nationwide system to identify doctors who threaten lives in their day-to-day medical practices.

To remedy these problems, I will introduce legislation next week to plug the loopholes in the Secretary's powers to sanction unfit practitioners. While my bill closely parallels H.R. 1370, I would like to comment very briefly on two areas in which it differs.

First, my bill specifies five offenses, including criminal use of a controlled substance and neglect or abuse of a patient, for which the Secretary is required to exclude a practitioner from Federal programs. H.R. 1370 leaves the decision to exclude or not in these cases to the discretion of the Secretary. My rationale in requiring exclusion for these criminal offenses is that they pose a deadly threat to both the health and safety of the patients and to the fiscal integrity of the programs. These five offenses are at least as serious as those for which the Secretary is currently required to exclude. I believe these most dangerous offenses should be treated uniformly for the protection of all involved.

The second difference is that my bill includes an amendment to the Controlled Substances Act, whereas I understand this amendment is a separate bill here in the House (H.R. 1369). Mr. Chairman, I cannot stress how crucial this amendment is to our crusade to shut down the shops of these unfit doctors. Over one-third of the practitioners cited in the GAO report were involved in illegal drug sales or drug trafficking. An Attorney General armed with the authority to revoke a drug license from any practitioner excluded from the Medicare program is an Attorney General equipped to protect other innocent citizens from these unscrupulous quacks.

Mr. Chairman, I believe the addition of the authorities in my bill and the House version constitutes an important step toward reasonable administration of our health care programs. I commend you and your colleagues for taking swift action of this critical issue. Our poor and aged constituents deserve nothing less than prompt passage of this legislation.

I would be happy to answer any questions of the distinguished members of this panel.

Mr. STARK. Thank you very much.

Mr. WAXMAN. I just want to commend the Senator on his testimony and his leadership in this area, and hope he will introduce legislation as soon as he possibly can.

Mr. MOORE. Mr. Chairman, I want to thank the Senator, too, and hopefully we will have this bill on our suspension calendar and passed to the Senate where he can look after it for us on the Senate side in quick order.

Senator HEINZ. Send us all your good bills.

Mr. STARK. We expected to see it as an amendment on the trade bill.

Mr. WYDEN. I only want to thank the Senator as well for a great, great job. And, Senator, I would hope that we could work with you as well so we can take care of the fraudulent doctor issue as well. We heard today from Mr. Kusserow that there are as many as a dozen rings operating in this country selling fraudulent degrees. We have one in Oregon that just sold 2,500 phony degrees. And we would like to work with you to see if you could have language to stop phony doctors and degree scams put in your bill as well.

Senator HEINZ. We would be pleased to work with you, Congressman Wyden. I have enjoyed working with you and the other members of the committee in the past. Mr. Kusserow has been busy. He was over on our side last week testifying about unnecessary surgery, and I commend him for that.

I wish I could say that the Department's position on mandatory second opinions accorded with their inspector general's.

Mr. STARK. The committee will recess for 20 minutes.

[Brief recess.]

Mr. STARK. We have Mr. Moore's permission to begin without him, and I would ask both Mr. Heeren and Mr. Lesser if they would summarize their testimony in any way that they would like within the confines of our 5-minute rule, and ask Mr. Heeren if he would like to proceed first.

STATEMENTS OF RUSSELL HEEREN, MEMBER, NATIONAL LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS; AND LEONARD LESSER, SPECIAL COUNSEL, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HEEREN. Thank you, Mr. Chairman. I appreciate this opportunity to share with the subcommittee the American Association of Retired Persons, AARP's, views on H.R. 1370, The Medicare and Medicaid Patient and Program Protection Act of 1985 and H.R. 1091, the Medical Impostors Act of 1985.

My name is Russell Heeren, and I am a member of the American Association of National Legislative Counsel, which is responsible for the AARP's Federal and State legislative policy.

AARP is the Nation's largest organization of older citizens, representing 18 million members over the age of 50. AARP is duly committed to cost containment and quality health care. AARP supports health care cost containment and restraints on the rate of increases in national health care spending, while restructuring the health care delivery system.

However, AARP fully recognizes that as strategies for effective containment of health care costs are developed and implemented, the issue of quality of care becomes critical. H.R. 1370 and H.R. 1091 are important first steps toward protecting Medicare and Medicaid patients from incompetent health care providers.

Although H.R. 1370 is directed primarily toward fraud and abuse of Federal funds, AARP sees the potential for the expansion of patient protections.

Currently, the Secretary of Health and Human Services has no authority to bar practitioners from Medicare and Medicaid participation based upon the disciplinary actions of State licensing boards. Although practitioners must hold a valid State license to participate in Medicare and Medicaid, nothing prevents a practitioner who loses his or her license in one State from obtaining a license in another State and continuing to participate in Medicare and Medicaid.

In addition, health providers who are excluded from either Medicare or Medicaid can continue to participate in the other programs. H.R. 1370 has the potential to correct these deficiencies.

There is much talk today of the so-called crisis in medical malpractice. AARP has long been concerned that the issue of medical malpractice litigation is eclipsing the crucial element of the malpractice problem—that is, the actual occurrence of malpractice, which results from the delivery of substandard care.

By strengthening the ability of the Secretary to prevent the provision of care by incompetent or unlicensed practitioners, H.R. 1370 and H.R. 1090 are important steps in mitigating actual occurrences of medical malpractice. H.R. 1370 could be made more effective if the license revocation of a provider were made a mandatory exclusion from Medicare and Medicaid participation, rather than the permissive exclusion.

AARP cannot envision a situation where a provider whose license has been revoked by a State licensing authority should be allowed to continue participating in either Medicare or Medicaid. AARP believes that the public has the right to know the consequences of advice from whom they receive health care services. This right to know becomes particularly compelling in light of the recent push in some quarters to limit recovery amounts of medical malpractice actions.

It should be clear that we cannot squeeze the patient at both ends. We cannot continue to deny access to provider specific information at the same time that we consider limiting patients' damages when they are the victims of incompetent providers.

As a first step toward assisting consumers in the choice of competent and licensed providers, AARP urges a strong provision for public disclosure of those providers excluded from participating in Medicare and Medicaid Programs. However, moreover, H.R. 1370 should serve as the impetus for a clearinghouse of provider specific information under the Secretary.

In order to close the circle so that information on providers is located in one place and available to licensing boards and other similar entities, AARP urges that the peer review organizations also be required to report to the Secretary their provider specific information that bears on the issues of competence, fraud and abuse.

Assuring high-quality medicine requires constant attention to quality of care mechanisms, so that quality is maintained before the fact, not after it. AARP believes that the improvement in H.R. 1370 and H.R. 1091 would better assure that only qualified practitioners treat Medicare and Medicaid beneficiaries.

AARP looks forward to working with the Congress on this and other measures to ensure that quality of care is not compromised as the costs of care are controlled.

Thank you.

[The prepared statement of Mr. Russell Heeren follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on
 HR 1370, THE MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1985
 and
 HR 1091, THE MEDICAL IMPOSTERS ACT OF 1985
 before the
 UNITED STATES HOUSE OF REPRESENTATIVES
 SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS
 and
 SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT, COMMITTEE ON ENERGY AND COMMERCE

March 19, 1985

1. AARP is dually committed to cost containment and quality health care. As strategies for effective containment of health care costs are developed and implemented, the issue of quality of care becomes critical.
2. HR 1370 and HR 1091 are important first steps toward protecting Medicare and Medicaid patients from incompetent health care providers. In particular, HR 1370 has the potential to correct current deficiencies which allow a practitioner who loses his/her license in one state to obtain a license in another state and continue to participate in Medicare and Medicaid.
3. A critical element of today's so-called "crisis" in medical malpractice is the mitigation of actual occurrences of malpractice which result from the delivery of substandard care. By strengthening the ability of the Secretary to prevent the provision of care by incompetent and/or unlicensed practitioners, HR 1370 and HR 1091 are important steps in mitigating actual occurrences of medical malpractice.
4. HR 1370 could be made more effective if the license revocation of a provider were a mandatory exclusion from Medicare and Medicaid participation rather than a permissive exclusion. AARP cannot envision a situation where a provider whose license has been revoked by a state licensing authority should be allowed to continue participation in either Medicare or Medicaid.
5. The public has the right to know the competence of providers from whom they receive health care services. As a first step toward assisting consumers in the choice of competent and licensed providers, AARP urges a provision for public disclosure of providers excluded from participation in Medicare and Medicaid. So that information on providers is located in one place and available to licensing boards and similar entities, Peer Review Organizations should also be required to report to the Secretary their provider specific information that bears on the issue of competence, fraud, and abuse.

Thank you, Mr. Chairman, for this opportunity to share with the Subcommittees the American Association of Retired Persons' (AARP) views on HR 1370, The Medicare and Medicaid Patient and Program Protection Act of 1985 and HR 1091, The Medical Imposters Act of 1985. My name is Russel Herren and I am a member of the Association's National Legislative Council, which is responsible for AARP's federal and state legislative policy. AARP is the nation's largest organization of older citizens, representing 18 million members over the age of 50.

AARP is dually committed to cost containment and quality health care. AARP supports health care cost containment that restrains the rate of increase in national health care spending while restructuring the health care delivery system. However, AARP fully recognizes that as strategies for effective containment of health care costs are developed and implemented, the issue of quality of care becomes critical. HR 1370 and HR 1091 are important first steps toward protecting Medicare and Medicaid patients from incompetent health care providers. Although HR 1370 is directed primarily toward fraud and abuse of federal funds, AARP sees the potential for the expansion of patient protections.

HR 1370 provides Medicare and Medicaid beneficiaries with improved protection against the delivery of substandard health care. The legislation expands the exclusion authority of the Secretary of Health and Human Services to bar providers from treating

Medicare and Medicaid patients when these providers are convicted of certain criminal acts, engage in fraud and abuse, or provide incompetent care. HR 1091 complements HR 1370 by imposing penalties and sanctions on unlicensed or falsely licensed physicians who provide care to Medicare and Medicaid beneficiaries.

The recent GAO report, Expanded Federal Authority Needed To Protect Medicare and Medicaid Patients From Health Practitioners Who Lose Their Licenses, clearly outlines the need for the expansion of the Secretary's exclusion authority. Currently, the Secretary of Health and Human Services has no authority to bar practitioners from Medicare and Medicaid participation based upon the disciplinary action of state licensing boards. Although practitioners must hold a valid state license to participate in Medicare and Medicaid, nothing prevents a practitioner who loses his/her license in one state from obtaining a license in another state and continuing to participate in Medicare and Medicaid. In addition, health providers who are excluded from either Medicare or Medicaid can continue to participate in the other program. HR 1370 has the potential to correct these deficiencies.

There is much talk today of the so-called "crisis" in medical malpractice. AARP has long been concerned that the issue of medical malpractice litigation is eclipsing the critical element of the malpractice problem, i.e., the actual occurrences of malpractice which result from the delivery of substandard care. AARP supports efforts by the government and the medical profession to more aggressively identify and deal with the incompetent practitioners that account for a disproportionate share of malpractice problems, including procedures for corrective action (sanctioning, license revocation, etc.) in those instances where providers are responsible for incompetent and/or negligent care. By strengthening

the ability of the Secretary to prevent the provision of care by incompetent and/or unlicensed practitioners, HR 1370 and HR 1091 are important steps in mitigating actual occurrences of medical malpractice. HR 1370 could be made more effective if the license revocation of a provider were made a mandatory exclusion from Medicare and Medicaid participation rather than a permissive exclusion. AARP cannot envision a situation where a provider whose license has been revoked by a state licensing authority should be allowed to continue participation in either Medicare or Medicaid.

AARP believes that the public has the right to know the competence of providers from whom they receive health care services. This right to know becomes particularly compelling in light of the recent push in some quarters to limit recovery amounts in medical malpractice actions. It should be clear that we cannot squeeze the patient at both ends. We cannot continue to deny access to provider specific information at the same time that we consider limiting patients' damages when they are the victims of incompetent providers.

As a first step toward assisting consumers in the choice of competent and licensed providers, AARP urges a strong provision for public disclosure of those providers excluded from participation in Medicare and Medicaid programs. Moreover, HR 1370 should serve as the impetus for a clearinghouse of provider specific information under the Secretary. In order to close the circle so that information on providers is located in one place and available to licensing boards and other similar entities, AARP urges that the Peer Review Organizations also be required to report to the Secretary their provider specific information that bears on the issues of competence, fraud and abuse.

Assuring high quality medicine requires constant attention to quality of care mechanisms so that quality is maintained before the fact, not after it. AARP believes that the improvements in HR 1370 and HR 1091 would better assure that only qualified practitioners treat Medicare and Medicaid beneficiaries. AARP looks forward to working with the Congress on this and other measures to ensure that quality of care is not comprised as the costs of care are controlled.

Mr. STARK. Thank you very much, Mr. Heeren.

Mr. Lesser, would you like to proceed at this time?

STATEMENT OF LEONARD LESSER

Mr. LESSER. Thank you, Mr. Chairman. My name is Leonard Lesser, I am special counsel to the National Council of Senior Citizens, and I am accompanied by Janet Myder, who is deputy director of the Office of Legislation and Research of the council.

Since our statement will appear in the record, I will just summarize briefly our major concerns.

We are appearing before this committee on behalf of the 4 million senior citizens represented by the national council to support the pending legislation which will protect health care consumers from fraudulent, unfit, unqualified, or unethical practitioners or providers of medical care or services.

Assuring quality of care is, however, only one of the ways that Congress can try to protect patients. Equally important is ensuring financial access to medical services.

Today's hearing occurs at a crucial time for senior citizens. Their out-of-pocket medical costs consume increasing proportions of their income, yet Members of the Senate and possibly the House will be deliberating budget proposals which would both decrease Social Security income for the aged and increase financial barriers to physician services.

The Senate Budget Committee has already taken decisive steps toward that end. We do not believe that these committees or the Congress can simultaneously pursue proposals to assure quality care, and at the same time support measures that result in the price of that care becoming unaffordable. Service of high quality, free of fraud, means little to the individual who cannot afford to go to the doctor.

We support the basic proportions of H.R. 1370, but we believe, however, that they can be strengthened to assure that its protections are more meaningful to those it covers and more are covered by its protections.

I will focus on three aspects of the bill: The limitation of exclusions to conviction for criminal offenses, related only to public programs; the need for more specific Congressional standards; and the access of patient consumers to information.

H.R. 1370 justifiably calls for excluding from Medicare and Medicaid those individuals or entities convicted of criminal offenses relating to these programs or other programs under the definition of, "State health care programs." However, if the goal of the proposal is patient and program protection, should not the Congress also exclude from participation those convicted of criminal offenses relating to neglect or abuse of patients, regardless of whether the offense occurred under a federally or State financed program?

Let me illustrate with three examples. Is a physician convicted of molesting patients who are insured primarily by private payers anymore fit to participate in Medicare or Medicaid than a physician convicted of molesting Medicare or Medicaid patients? Is a nursing home administrator convicted of fraudulently obtaining

payments from private paying patients anymore fit to participate in Medicare than one convicted of defrauding Medicaid?

The National Council of Senior Citizens, therefore, recommends that H.R. 1370 be broadened to apply the mandatory and permissive exclusions to all individuals and entities convicted of criminal offenses related to the delivery of medical care and services to patients covered by nonpublic as well as Federal and State payers.

I would also like to comment on the provisions for permissive exclusion from Medicare. Senator Heinz raised the point, and I would like to reaffirm what he had to say and indicate that the permissive exclusion is given to the Secretary in a broad range of cases. In fact, the new provision added to the bill where a doctor is disqualified in one State, or where his license is taken away from him in one State, is put under the permissive exclusion provisions of the bill.

We recognize that there may be circumstances which may not warrant automatic exclusion and which we are not giving to the Secretary some discretion. However, we believe that the bill should apply or should provide specific congressional standards as to when the Secretary may exercise his discretion.

We are particularly concerned about the permissive exclusion allowed in areas of patient health and safety. For example, why should the Secretary have the discretion to permit an individual or an entity to treat Medicare patients if such individual or entity has been convicted of a "criminal offense relating to neglect or abuse of patients". I have quoted from the new section, 1128(b) in the bill. Why the inclusion of "at the Secretary's discretion" if services rendered to non-Medicare or State health care program patients are substantially "in excess of the needs of such patients, or of a quality which fails to meet the professionally recognized standards of care"? That quote is taken from section 1128(6)(b)(C).

And I would refer again to the point Senator Heinz did of the revocation of the license in one State. Thank you.

[The prepared statement of Mr. Lesser follows:]

Medicare and Medicaid Patient and Program
Protection Act of 1985 (H.R. 1370)

Statement by

Leonard Lesser, Special Counsel

National Council of Senior Citizens
925 15th Street, N.W.
Washington, D.C. 20005

Before the Health Subcommittees of the
Ways and Means Committee and
Energy and Commerce Committee
in a joint hearing

March 19, 1985

Chairman Waxman, Chairman Stark, Committee Members, I am Leonard Lesser, Special Counsel to the National Council of Senior Citizens. On behalf of the four million senior citizens that the National Council represents, I present testimony supporting legislation which will protect health care consumers from fraudulent and unfit medical practitioners.

NCSC has long been a champion of health care since its founding 23 years ago during the fight for passage of Medicare legislation. We are as concerned now about access, cost, quality, and the capacity of programs to meet the elderly's medical needs as we were in the 1960s when Medicare and Medicaid did not exist. We are growing increasingly concerned today about the erosion of protection provided by Medicare and Medicaid.

The National Council of Senior Citizens believes that there are many ways to protect individuals whose medical care is financed by Medicare and Medicaid. Monitoring and assuring the

quality of services provided are vital steps toward this protection. Ensuring the integrity of providers participating in the program is an important component of these steps.

However, assuring quality is only one of many ways that Congress can try to protect patients. Equally important, and also a prerequisite, is assuring financial access to medical services. We believe that Congress cannot simultaneously pursue quality care and allow the price of that care to become unaffordable. Service of high quality, free of fraud, means little to the individual who cannot afford to go to the doctor.

Let us keep in mind that today's hearing occurs at a crucial time for senior citizens. Their out-of-pocket medical costs consume increasing proportions of their incomes. However, members of the Senate and possibly many in the House are deliberating on budget proposals which would both decrease Social Security income for the aged and increase financial barriers to physician services. The Senate Budget Committee has already taken a decisive, partisan step toward that end.

We commend the sponsors of the patient protection bills now before the Committee. We urge the sponsors and all of the Committee members to remain as concerned about citizens' financial access to quality health care as they clearly are about their protection from fraudulent or unfit providers.

The National Council of Senior Citizens considers H.R. 1369, H.R. 1370, and H.R. 1091 to be very important steps toward the protection of senior citizens, the country's major health care

consumers. We believe that the proposals can and should reach the dual goals of patient protection and Federal program protection.

The bills address two very important issues:

- ° Individuals covered by Medicare and Medicaid, like all others, should expect that the medical care they receive is necessary and appropriate, and provided by licensed or certified providers and practitioners who comply with such codes as state and Federal laws and regulations, ethical and medical practice guidelines, and applicable reimbursement policies.
- ° The Federal government, as payer rather than provider of medical care, has the responsibility to the program's recipients and the taxpayers to assure that the services purchased under Medicare and Medicaid are appropriate, necessary, and provided by individuals and entities in compliance with the codes mentioned previously.

The need for stronger patient protection mechanisms is becoming increasingly apparent to us as representatives of Medicare enrollees. The cost of medical care is rising while Federal budgetary constraints are being imposed on public spending on health. Recent and proposed Medicare and Medicaid reimbursement reforms and limitations may be achieving the government's financial goals, but the cost to patients must be very carefully monitored in the process. Let me cite a few hypothetical, but very possible, examples:

- ° A necessary treatment or procedure is omitted from a patient's regimen to increase the hospital's or HMO's financial gain.
- ° A physician fraudulently bills Medicare or overcharges the patient to compensate for income lost during the payment freeze.
- ° An HMO administrator, anxious to increase market share in areas with high concentrations of Medicare beneficiaries, insufficiently investigates the credentials of the professionals hired to staff a new unit.

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We recognize that prohibitions exist to protect against, and discourage such actions. We also recognize that compliance monitoring and quality assurance systems are in place to identify abuse. However, we believe that the bills before the Committee today would provide needed adjuncts to existing protection and would provide for stronger penalties to deter violations.

Just as access to quality care depends on affordable prices as well as quality assurance, so does patient protection depend on elements other than the penalties provided for in these bills. The adequacy or strengthening of patient and program protection depends on such Federal, state, and local components as: monitoring compliance and identifying noncompliance; application of sanctions/disciplinary actions; data generation, reporting, and sharing.

To state our concerns simply: These bills cannot protect us unless violators are caught and prosecuted or disciplined. Patient protection mechanisms must be operative and effective at every step of the way leading up to the Federal protections called for by these bills.

Now I will turn specifically to H.R. 1370 to identify some of our concerns, questions, and recommendations. I will focus on three aspects of the bill: the limitations of exclusions to conviction for criminal offenses related only to public programs; the need for more specific standards; and the access of patients/consumers to information.

H.R. 1370 justifiably calls for excluding from Medicare and Medicaid those individuals or entities convicted of criminal offenses relating to these programs, or others under the definition

of "state health care programs." However, if the goal of the proposal is patient and program protection, would Congress not want to also exclude from participation those convicted of criminal offenses relating to other payers?

Let me illustrate with two examples. Would a physician convicted of molesting patients who are insured primarily by private payers be any more fit to participate in Medicare than a physician convicted of molesting Medicare or Medicaid patients? We believe that he would not be. Would a nursing home administrator convicted of fraudulently obtaining payments from private-paying patients be any more fit to participate in Medicare than one convicted of defrauding Medicaid? We believe that he would not.

The National Council of Senior Citizens recommends, therefore, that H.R. 1370 be broadened to apply the mandatory and permissive exclusions to individuals and entities convicted of criminal offenses relating to the delivery of medical care and services to patients covered by non-public payers.

H.R. 1370 provides for "permissive exclusion" from Medicare those individuals and entities convicted of a variety of criminal offenses and violations of the laws and regulations under the program. We recognize that there are many variable circumstances which may not warrant complete exclusion and which warrant granting the Secretary discretion in applying the exclusion. However, we believe that the proposal gives the Secretary too much discretion in areas for which Congress should provide specific standards.

We are particularly concerned about the permissive exclusions allowed in areas of patient health and safety. For example,

why is exclusion dependent on the Secretary's discretion if an individual or entity has been convicted of a "criminal offense relating to neglect or abuse of patients" [new Section 1128(b)(1)(B)]? Why is exclusion at the Secretary's discretion if services rendered to Medicare or state health care program patients is "substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of care" [new Section 1128(b)(6)(C)]?

The National Council of Senior Citizens recommends that exclusions for offenses relating to patients' health and safety be made mandatory.

The third area of our concern is that of information available to the patient or consumer. H.R. 1370's effectiveness depends heavily on the generation and sharing of data concerning providers of health care services. The bill provides for dissemination of information among public programs, state licensing agencies, etc. However, the bill omits specific reference to providing information to the patient or consumer whose protection is the target of the Act.

How will a Medicare beneficiary know if a provider or supplier has been excluded from participating in Medicare? To what source can the beneficiary turn for the information? We believe that if Medicare beneficiaries are to be fully protected under this Act, they must have access to such information.

The growing body of information, for example, physician assignment rate lists, now available to Medicare beneficiaries has enabled them to make choices as informed consumers. While we still have a long way to go in making other information such

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as pricing practices available to consumers, progress has been made. Through H.R. 1370 there is an opportunity and also a necessity to expand consumer information.

A potential source of information for patients is the fiscal intermediaries. They will need to receive and maintain timely data on excluded providers. Intermediaries currently operate two consumer information vehicles, the toll-free telephone lines and the physician assignment rate/participation lists. We believe these vehicles could be used to disseminate information on excluded providers as well.

Our final concern is patients' financial protection under H.R. 1370. New Section 1862(e) states that payment will not be made for services provided during the exclusionary period. We recommend that this section also include a provision that the Medicare beneficiary is not liable for the cost of services rendered by an excluded practitioner.

The National Council of Senior Citizens thanks you for this opportunity to present our views on patient protection.

Mr. STARK. Thank you very much, Mr. Lesser.

Mr. Waxman.

Mr. WAXMAN. I would commend both of these gentlemen for their testimony and for those who assisted them in producing their comments to us today. I think you have given us some very thoughtful points, and we ought to look at them very carefully as we discuss this legislation. Thank you very much.

Mr. MOORE. Mr. Chairman, I also want to thank both these witnesses, as well as the two witnesses before them, for correctly understanding that this legislation is trying to help primarily the constituencies they are representing. And we certainly appreciate your seeing that and supporting us.

Mr. WYDEN. Just one quick question. As you know, there have been a number of budget cuts proposed, which would create extra charges for the beneficiaries. Isn't it better to start saving money with these kinds of bills, Mr. Moore's and my own, to concentrate on eliminating fraud, inefficiency, and abuse first, before we think about increasing charges to seniors?

Mr. LESSER. Well, I agree completely, Mr. Wyden. In fact, I pointed out that I think it is inconsistent to talk about quality of care when costs are being increased so that an awful lot of people may not be able to get the care. And I would certainly urge that all attempts at containing costs and saving moneys be directed at the fraudulent, the cheaters, the criminals, and not impose the burden on the aged who have already been subject to increases in premium costs under Medicare and suspension of the COLA under Social Security.

Mr. WYDEN. Mr. Moore and I share your objective, and that's why we are pushing these pieces of legislation. And we thank you for your support.

Mr. STARK. I want to thank all the witnesses in today's hearing for their splendid cooperation in moving these along.

There is a 3 o'clock Democratic Caucus, at which time a few of us on the Democratic side are going to try and postpone the MX missile, which will give us enough money to proceed with some of the Medicare benefits, things we'd like to see.

Mr. MOORE. Mr. Chairman, I would just like to conclude by saying I want to thank both you and the chairman of the Health Subcommittee of the House Energy and Commerce Committee for both coauthoring this legislation. And I thank you for holding the hearings so expeditiously and together so we can move quickly.

As Mr. Wyden and I were talking between votes, we ought to do this more often. It enables us to move very quickly on legislation that is not controversial.

I also want to compliment Mr. Wyden on his legislation.

Mr. WYDEN. I thank the gentleman.

[Whereupon, at 3 p.m., the meeting was adjourned.]

[The following statements were submitted for the record:]

**STATEMENT OF THE
AMERICAN HEALTH CARE ASSOCIATION**

ON

**H.R. 1370, MEDICARE AND MEDICAID PATIENT AND
PROGRAM PROTECTION ACT OF 1985**

TO THE

**U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH**

AND

**COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT**

MARCH 19, 1985

The American Health Care Association, representing approximately 8,500 nursing homes and allied long term health care providers, appreciates this opportunity to submit testimony about H.R. 1370, the Medicare and Medicaid Patient and Program Protection Act.

AHCA supports efforts to deter, identify and sanction fraud and abuse of public funds; to protect beneficiaries from unfit providers and practitioners; and to clarify and integrate existing related provisions of the Social Security Act. In general, while we believe the proposed legislation seeks to achieve these objectives, there are several of its sections that raise serious concerns.

**Section 2 -- Exclusion from Medicare and State Health Care Programs:
Amendment of Section 1128(b) Permissive Exclusion.**

In some parts of Section 1128(b), a final decision as to the basis for suspension (e.g., conviction in paragraphs (1), (2) and (3)) is required prior to suspension. However, the requirement of a final decision is not always clear. We believe that fairness and due process considerations mandate that a final legally sustainable decision that a provider has acted improperly or failed to act properly is required. Specific paragraphs that should be revised to meet due process requirements are as follows:

- o In paragraph (4) License Revocation or Suspension, language should be added to make clear that a final decision should have been made prior to suspension.

- o By removing paragraph (6) Submission of False Claims, from Section 1862, there is no longer a definition of (final) determination, by the Secretary, of the actions identified in this section. Due process considerations require that a final determination be made before a penalty can be imposed.
- o The same due process considerations apply in paragraphs (8) Exclusion of Entities, (9) Failure to Disclose Required Information, (10) Failure to Supply Requested Information, and (11) Failure to Supply Payment Information. In each of these paragraphs, there are questions of fact which must be resolved prior to imposition of a sanction.

Other concerns about amendment of Section 1128(b) are the following:

- o Paragraph (7) Fraud, Kickbacks and Other Prohibited Activities: We believe this is already covered in proposed Section 1128A(a) Mandatory Suspension.
- o Paragraph (12) Failure to Provide Immediate Access to Necessary Information: We are concerned that permitting the Secretary to impose a sanction against a provider who fails to provide "immediate access" to investigators could have a chilling effect upon providers' exercise of their rights, especially as it relates to subsections (C) and (D) Access by the Inspector General or State Medicaid Fraud Unit, where possibility of criminal investigation exists. Either statutory provision should be made for reasonable opportunity for the provider to consult with counsel or a probable cause standard should be met before immediate access is required.

The phrase "immediate access, upon reasonable request" requires definition. Additionally, a final decision that the provider acted improperly should be required prior to suspension.

Section 2 -- Exclusion from Medicare and State Health Care Programs: Amendment of Section 1128(d) Hearing and Judicial Review on Exclusions.

If Section 1128(b) is changed so as to require final decisions prior to suspension, as we suggested above, this hearing process is reasonable. If, however, it is contemplated that the hearing process under this section would also include making final determinations as to improper actions of providers, we believe that a hearing prior to suspension is required.

Section 3(f) -- Civil Money Penalties: Application of Subpoena Power and Injunctive Powers.

We find it difficult to understand the intent and application of this section. First, we believe the Secretary has power under existing law to request courts to enjoin improper or illegal actions. We do not believe this section is necessary.

Second, we do not believe that there is any basis in law for attempting to enjoin actions of a person whom the Secretary "has reason to believe" is "about to engage in any activity which makes the person subject to a civil money penalty." We suggest that in any situation in which it would be possible to prove that a person is "about to engage" in impermissible activity, already existing law would apply.

Third, if the purpose of the section is to prevent a provider whose activity is under investigation from removing, concealing or encumbering assets, this section should be restricted so as to achieve that objective.

Section 5(b) -- Information Concerning Sanctions Taken by State Licensing Authorities Against Health Care Practitioners and Providers: Amendment of Section 1919(a)(1) Information Reporting System.

The state should be required to have a system to prevent release of information other than as authorized in this section in addition to the confidentiality provision applicable to the Secretary in Section 1919(c).

AHCA would be pleased to respond to any questions that these comments generate.

Statement of the

AMERICAN MEDICAL CARE AND REVIEW ASSOCIATION

Mr. Chairman, my name is Gaylord C. Weeks. I am a practicing physician from Oregon City, Oregon, and I am the current President of the American Medical Care and Review Association (AMCRA).

AMCRA is the national organization which represents the physician practitioners and member health plans that now sponsor a variety of community-based options for providing health care through cost-effective alternative delivery systems. AMCRA represents individual practice association-type health maintenance organizations (IPA/HMOs), preferred provider organizations (PPOs), and foundations for medical care (FMCs). The Association's present membership includes organizations representing over 54,000 participating physicians and which have a combined enrollment of over 2,800,000. On behalf of AMCRA, I am pleased to have this opportunity to present our views and comments on H.R. 1370, the Medicare and Medicaid Patient and Program Protection Act of 1985 and on H.R. 1091, the Medical Imposters Act of 1985.

The Medicare and Medicaid Patient and Program Protection Act of 1985 would require the Secretary of Health and Human Services to exclude from Medicare (Title 18 of the Social Security Act) and the States to exclude from Federally-aided Medicaid (Title 19), the maternal and child health program (Title 5) and the social services program (Title 20), any individual or entity convicted of a criminal offense related to those programs for a minimum of five years. The Secretary would be permitted to exclude from Medicare (and upon such exclusion, the States would be required to exclude from the above-mentioned State programs) any individual or entity convicted of certain offenses such as fraud, financial abuse, and neglect or abuse of patients.

The Medical Imposters Act of 1985 would authorize the Secretary to impose a criminal penalty under Medicare and Medicaid on a physician

who was not licensed, whose license had been obtained through misrepresentation of material fact, or who represented to a beneficiary that he was board certified in a medical specialty and was not. This bill would also provide for a civil money penalty for such misrepresentations.

In general, Mr. Chairman, AMARA strongly endorses the objectives of the proposals to improve the antifraud provisions that now apply to Medicare and to certain other Federally-aided health care financing programs. We share the concerns of the Members of your committees that additional steps should be taken to protect both patients and taxpayers from any practitioners who cannot satisfy minimum State requirements that they meet minimum professional standards. We also strongly believe that the Federal Government, as a purchaser of services for the aged, the poor and the disadvantaged, should have the authority to exclude individuals and others who have been convicted of certain nonprogram related crimes such as fraud, financial abuse, neglect of patients and the unlawful distribution of controlled substances.

Mr. Chairman, we note, however, that the proposed Medicare and Medicaid Patient and Program Protection Act of 1985 differs from similar legislation taken up and reported by the Ways and Means Committee last year. Specific references are now made in the bill to health maintenance organizations (HMOs) and to certain other entities in Medicaid and to entities in section 1876 of the Social Security Act--namely, HMOs and competitive medical plans participating in the Medicare program.

Mr. Chairman, we certainly do not believe that HMOs or competitive medical plans should be excluded from the application of certain fraud and abuse provisions in the legislation. But, we are concerned about the need to clarify further the reasons for which the Secretary would be authorized to exclude HMOs and competitive medical plans from

participation in Medicare and Medicaid. The present language refers to entities that have "failed in a substantial number of cases to provide medically necessary items and services that are required under law" or under contract with either the State or Federal Government. While we believe you have in mind identifying abuses of the most egregious nature, we are somewhat apprehensive about how such a test might be established or applied in actual practice. "Medical necessity" is a term whose meaning is not always agreed upon and may lead to differing interpretations of the provisions included in the bill.

We would ask your committees, therefore, to give very careful attention to these concerns before approving the legislation in its present form. We have only begun to develop across the country the kind of standards needed with which to measure the provision of services in excess of the needs of patients. We have even less of a widely-accepted body of information against which to measure presumed underservice that represents abuse. The development of such criteria are essential, before steps are taken to deny participation in these most important health care financing programs. We would be pleased to lend our support to any cooperative efforts you may wish to take to develop such criteria in order to achieve the purposes of this legislation.

On behalf of the American Medical Care and Review Association, thank you for this opportunity to share our thoughts about these matters.



Communities that Care

National Organization
of Nonprofit Homes and
Services for the Elderly

American Association of Homes for the Aging
1050 17th Street, NW, Suite 770
Washington, DC 20036
202 • 296 • 5960

William R. Thayer
President
Sheldon L. Goldberg
Executive Vice President

March 29, 1985

Mr. Joseph K. Dowley, Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
Room 1102 Longworth House Office Building
Washington, D.C. 20515

To Whom It May Concern:

On behalf of the American Association of Homes for the Aging (AAHA) we are pleased to have this opportunity to convey our views on H.R. 1370, the Medicare and Medicaid Patient and Program Protection Act of 1985.

AAHA is a national nonprofit, representing approximately 2500 nonprofit homes, housing, health related facilities, and community services for the elderly. AAHA members are sponsored by religious, fraternal, labor, private, and governmental organizations committed to providing quality services for their residents.

In general, AAHA is very supportive of measures to protect beneficiaries from unfit health care practitioners. We are particularly supportive of provisions which would prevent physicians who lose their license in one state from obtaining a license in another state. Ensuring the integrity of health care providers is critical if we are to promote the quality of care for elderly Americans.

There are several ways in which we believe the bill can be strengthened. While H.R. 1370 would distribute information on health care providers to public programs, state licensing agencies, etc., AAHA believes that consumers should also have access to this information. Beneficiaries need to know whether a provider has been excluded from a program and why. Fiscal intermediaries may be an appropriate focal point for dissemination of this information to consumers. Second, AAHA believes that beneficiaries should not be liable for the cost of services rendered by an excluded practitioner during the exclusionary period under Section 1862(e). Language should be included to ensure that beneficiaries will not be forced to pay for services covered under public programs if they could not have reasonably known that the service was not reimbursable.

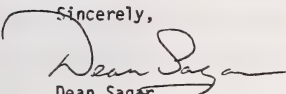
We also have several concerns and questions with regard to the bill. First, we are concerned that permissive exclusions under Section 2(b) comport with due process requirements and are triggered only by final decisions. It is unclear whether the activities articulated in subsection (b)(4-12) constitute a formal determination or judicial decision, or merely some preliminary finding. We recommend that these subsections be clarified so that permissive exclusions are triggered only by final decisions, in compliance with the due process under law. Additionally, if an adverse decision with regard to the activities of a provider is subsequently overturned in favor of the provider, such provider should not be excluded from any program.

Second, we are also concerned about Section 2(b)(12)-FAILURE TO PROVIDE IMMEDIATE ACCESS TO NECESSARY INFORMATION. We feel there is potential for abuse in this subsection in that the term "immediate" is subject to interpretation and may be excusable for good reasons. We believe that a reasonable period of time should be permitted to provide information, that "immediate" should not be taken literally, and that extenuating circumstances be considered in instances where prompt availability is not possible.


Finally, we are concerned about Section 3(s)(j) (p.16, lines 15-25). We must question the necessity for language that permits an injunction whenever "the Secretary has reason to believe that any person ... is about to engage in" the activities articulated in this section. Current legal standards for the issuance of Temporary Restraining Orders and/or injunctions are sufficient to curtail the behavior of concern here. AAHA prefers a "probable cause" standard rather than a "reason to believe" standard, and recommends that the speculative "about to engage in" language be deleted.

With the minor changes articulated above, AAHA believes H.R. 1370 can be strengthened and would merit the broad support of consumers and providers. Thank you again for this opportunity to present our views on patient protection.

Sincerely,



Dean Sagar
Director of Government Affairs



Howard Bedlin
Legal Policy Analyst



STATEMENT FOR THE RECORD
OF
CAROLYNE K. DAVIS, Ph.D.
ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
AND THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 19, 1985

THANK YOU FOR THE OPPORTUNITY TO SUBMIT A STATEMENT FOR THE RECORD ON TWO BILLS RELATED TO MEDICARE AND MEDICAID FRAUD: H.R. 1091, "THE MEDICAL IMPOSTORS ACT OF 1985" AND H.R. 1370, "THE MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1985".

THE MEDICARE AND MEDICAID PROGRAMS PROVIDE BASIC HEALTH CARE SERVICES FOR THE ELDERLY AND THE POOR. IN 1984, MEDICARE AND MEDICAID PAID ALMOST \$80 BILLION FOR HEALTH CARE BENEFITS TO 43 MILLION BENEFICIARIES. IN ADDITION TO PROVIDING FINANCIAL ASSISTANCE, THE MEDICARE AND MEDICAID PROGRAMS ARE RESPONSIBLE FOR ASSURING THAT PAYMENT IS APPROPRIATE AND THAT HEALTH SERVICES MEET SPECIFIC STANDARDS.

UNDER PRESENT LAW, THE SECRETARY MAY EXCLUDE FROM PARTICIPATION IN THE MEDICARE PROGRAM PHYSICIANS AND OTHER HEALTH PROFESSIONALS WHO: (1) KNOWINGLY SUBMIT FALSE CLAIMS; (2) CHARGE SUBSTANTIALLY MORE THAN THEIR USUAL CHARGES TO OTHER PATIENTS; (3) PROVIDE SERVICES SUBSTANTIALLY IN EXCESS OF PATIENTS' NEEDS OR SERVICES WHICH FAIL TO MEET PROFESSIONALLY RECOGNIZED STANDARDS OF HEALTH CARE; OR (4) ARE FOUND BY A PEER REVIEW ORGANIZATION TO BE PROVIDING UNNECESSARY OR SUBSTANDARD CARE TO PROGRAM BENEFICIARIES. FURTHER, THE SECRETARY IS REQUIRED TO EXCLUDE INDIVIDUALS FROM MEDICARE AND MEDICAID WHO HAVE BEEN CONVICTED OF CRIMINAL OFFENSES RELATED TO THEIR PARTICIPATION IN THE RESPECTIVE PROGRAMS. IN ADDITION TO THESE EXCLUSION AND SUSPENSION AUTHORITIES, THE SECRETARY HAS THE ADMINISTRATIVE AUTHORITY UNDER THE CIVIL MONETARY PENALTIES PROVISIONS OF THE SOCIAL SECURITY ACT TO ASSESS FINANCIAL PENALTIES ON HEALTH

PROFESSIONALS AND OTHER INDIVIDUALS WHO FILE FALSE OR OTHERWISE IMPROPER CLAIMS FOR REIMBURSEMENT UNDER THE MEDICARE AND MEDICAID PROGRAMS.

THE OFFICE OF THE INSPECTOR GENERAL IS RESPONSIBLE FOR INVESTIGATING FRAUD AND ABUSE IN THE MEDICARE AND MEDICAID PROGRAMS, AND FOR SANCTIONING PHYSICIANS AND OTHER HEALTH CARE PROVIDERS FOR FRAUDULENT AND UNPROFESSIONAL ACTIVITIES. USING EXISTING AUTHORITIES, THE INSPECTOR GENERAL HAS SIGNIFICANTLY INCREASED THE NUMBER OF SANCTIONED HEALTH PROVIDERS AND THE AMOUNT OF FINANCIAL RECOVERIES IN THE LAST TWO YEARS.

DESPITE THIS EFFORT, THE SECRETARY HAS BEEN UNABLE TO TAKE NEEDED ACTION AGAINST CERTAIN HEALTH CARE PRACTITIONERS AND PROVIDERS WHO CONTINUE TO SERVE MEDICARE AND MEDICAID BENEFICIARIES. A PROVIDER CONVICTED OF FRAUD AND ABUSE UNDER THE MEDICAID PROGRAM MAY CONTINUE TO PARTICIPATE AS A MEDICARE PROVIDER. EVEN THOUGH OWNERS AND STAFF OF A FACILITY HAVE BEEN CONVICTED OF DEFRAUDING MEDICAID, THE FACILITY MAY CONTINUE TO RECEIVE MEDICARE AND MEDICAID PAYMENT AS LONG AS THE CONVICTED PERSONNEL ARE NOT PROVIDING DIRECT SERVICES TO PATIENTS. A PHYSICIAN WHO HAS LOST A LICENSE IN ONE STATE FOR GROSS NEGLIGENCE CAN MOVE TO ANOTHER STATE AND CONTINUE TO SERVE MEDICARE AND MEDICAID PATIENTS.

THE BILLS UNDER CONSIDERATION CONTAIN PROVISIONS WHICH SEEK TO CLOSE SUCH LOOPHOLES. FOR EXAMPLE, H.R. 1091, WOULD PROVIDE CIVIL MONETARY AND CRIMINAL PENALTIES FOR INDIVIDUALS WHO MISREPRESENT THEMSELVES AS PHYSICIANS OR SPECIALISTS AND CLAIM MEDICARE OR MEDICAID PAYMENT. H.R. 1370 WOULD ALLOW THE SECRETARY TO EXCLUDE ENTITIES CONVICTED OF DEFRAUDING OR ABUSING THE MEDICAID PROGRAM FROM PARTICIPATING IN THE MEDICARE PROGRAM, AND OTHER FEDERAL HEALTH PROGRAMS. THE BILL WOULD ALLOW EXCLUSION OF PROVIDERS CONVICTED OF (1) FRAUD OR FINANCIAL ABUSE, (2) PATIENT ABUSE, OR (3) UNLAWFUL MANUFACTURE, DISTRIBUTION, OR DISPENSING OF CONTROLLED SUBSTANCES. IT WOULD ALSO ESTABLISH A MINIMUM EXCLUSION PERIOD OF 5 YEARS FOR INDIVIDUALS OR ENTITIES CONVICTED OF CRIMINAL OFFENSES.

H.R. 1370 WOULD MAKE A NUMBER OF CHANGES IN THE CIVIL MONETARY PENALTIES LAW, SUCH AS PERMITTING A COMBINED JUDICIAL REVIEW OF CIVIL MONETARY PENALTIES AND MEDICARE/MEDICAID SUSPENSIONS. ANOTHER PROVISION WOULD INCREASE A STATE'S SHARE OF RECOVERIES IN MEDICAID TO ENCOURAGE GREATER INVESTIGATION AND REFERRAL OF MEDICAID FRAUD CASES BY STATES. THE BILL WOULD ALSO PROVIDE A SIX-YEAR STATUTE OF LIMITATIONS AND CLARIFY THE SCOPE OF THE CIVIL MONETARY PENALTIES STATUTE TO INCLUDE PENALTIES FOR DOUBLE BILLING BY PROVIDERS AND RECOVERIES FROM INDIVIDUALS WITH FALSE MEDICAL CREDENTIALS.

IN ADDITION TO EXTENDING EXISTING AUTHORITIES, H.R. 1370 WOULD ADD A NEW PROVISION TO REQUIRE A STATE MEDICAL LICENSING AUTHORITY TO NOTIFY THE SECRETARY (OR HER DESIGNEE) WHEN IT

UNDERTAKES FORMAL PROCEEDINGS OR DISCIPLINARY ACTIONS AGAINST A HEALTH CARE PRACTITIONER. THE SECRETARY COULD EXCLUDE INDIVIDUALS WHO LOSE THEIR LICENSES FROM PARTICIPATION IN THE MEDICARE PROGRAM AND DIRECT STATE AGENCIES TO EXCLUDE THESE INDIVIDUALS FROM MEDICAID, AND PROGRAMS FUNDED UNDER THE SOCIAL SERVICES BLOCK GRANT (TITLE XX) OR MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT (TITLE V).

THESE PROVISIONS WOULD PROVIDE IMPORTANT AUTHORITY TO PROTECT THE FISCAL INTEGRITY OF THE MEDICARE AND MEDICAID PROGRAMS AND TO ADDRESS PROBLEMS THAT MAY ENDANGER THE HEALTH AND SAFETY OF PROGRAM BENEFICIARIES. HOWEVER, SEVERAL FEATURES OF THE NEW PROVISIONS RELATING TO ACTIONS OF STATE LICENSING AUTHORITIES RAISE CONCERN:

- O THE NEED TO INCREASE THE FEDERAL OVERSIGHT ROLE SHOULD BE CAREFULLY BALANCED WITH THE POSSIBILITY OF EXCESSIVE INTRUSION INTO MATTERS UNDER STATE JURISDICTION. THE SEPARATE JURISDICTION OF THE STATES IN DETERMINING THE FITNESS OF INDIVIDUALS TO PROVIDE HEALTH CARE SERVICES THROUGH A LICENSING FUNCTION VS. THE ROLE OF FEDERAL AND OTHER STATE AGENCIES IN ASSURING THE HEALTH AND SAFETY OF INDIVIDUALS RECEIVING HEALTH SERVICES THROUGH SPECIFIC PROGRAMS SHOULD BE PRESERVED.
- O THE PROVISION TO REQUIRE REPORTING AND ACCESS TO DOCUMENTS ON STATE LICENSURE ACTIONS THAT ARE NOT FINAL DECISIONS SHOULD BE SERIOUSLY EXAMINED --SUCH AS

SUMPTION OF GUILT WHEN A LICENSE IS VOLUNTARILY SURRENDERED, OR EXCLUDING A PRACTITIONER ON THE BASIS OF EVIDENCE FOUND INSUFFICIENT FOR A STATE BOARD TO JUSTIFY MORE THAN A REPRIMAND. THE NEED TO PROTECT BENEFICIARIES FROM POTENTIAL ABUSES SHOULD BE BALANCED WITH THE NEED TO ASSURE THE PROTECTION OF PRACTITIONERS FROM PREMATURE PENALTIES.

- O THE REPORTING REQUIREMENTS SHOULD ASSURE THAT MINIMAL BURDEN IS PLACED ON STATES AND PARTICIPATING AGENCIES, AND THAT INFORMATION IN THE SYSTEM AND USES OF THE SYSTEM ARE CAREFULLY DEFINED AND CONTROLLED. IN ADDITION, SUFFICIENT SAFEGUARDS SHOULD BE ESTABLISHED TO PROTECT PRACTITIONERS AND PROVIDERS.

CONCLUSION

IN CONCLUSION, WE ARE PLEASED WITH THE EFFORT TO RECODIFY THE PRESENT MEDICARE AND MEDICAID FRAUD AND ABUSE REQUIREMENTS INTO A SINGLE TITLE. WE ALSO AGREE WITH THE INTENT OF H.R. 1091 AND H.R. 1370 TO PROVIDE NEEDED AUTHORITY FOR THE SECRETARY TO TAKE ACTION AGAINST PROVIDERS WHO ARE HARMING OUR BENEFICIARIES OR ARE DEFRAUDING OUR PROGRAMS. HOWEVER, WE AND THE DEPARTMENT OF JUSTICE ARE CONCERNED THAT SPECIFIC PROVISIONS IN BOTH BILLS NEED TO BE CLARIFIED. FROM OUR PERSPECTIVE, WE MUST ASSURE THAT STATES' RIGHTS IN THESE MATTERS ARE NOT INFRINGED, THAT PROVIDERS' RIGHTS TO FAIR TRIAL AND CONFIDENTIALITY ARE PROTECTED, AND THAT BENEFICIARY ACCESS TO HEALTH SERVICES IS PROTECTED. WE WOULD BE PLEASED TO WORK WITH THE COMMITTEES TO RESOLVE OUR CONCERNS WITH THE BILLS.

THE DEPARTMENT OF JUSTICE IS REVIEWING BOTH H.R. 1370 AND H.R. 1091 AND WILL BE PREPARING BILL REPORTS ON THESE BILLS FOR THE RESPECTIVE COMMITTEES.

Testimony Submitted By

CESAR A. PERALES, COMMISSIONER
NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

I appreciate the opportunity to submit written testimony on behalf of the New York State Department of Social Services, the single state agency for the Title XIX and Title XX Programs.

New York State strongly supports the intent of H.R. 1370, the Medicare and Medicaid Patient Protection Act of 1985, which would remove individuals and entities convicted of certain criminal offenses related to government-funded health programs from participation in such programs on a nationwide basis.

New York has been in the forefront of anti-fraud and abuse program development with its ongoing commitment of personnel and computer resources. Since the inception of the program in 1976 to the present, there have been 565 permanent disqualifications of providers, 187 time-limited suspensions, and 201 other types of sanctions. Of the total of 953 disqualified providers, an estimated 250 providers were excluded from New York's Medicaid program specifically because the individuals or entities were convicted of a Medicare- or Medicaid-related crime.

New York considers the commission of a crime perpetrated by a medical professional against the publicly-supported health care programs as a serious breach of public trust, and accordingly, had adopted the policy of decreeing a permanent disqualification from Medicaid as opposed to the minimum five-year period provided for in H.R. 1370. While our policies permit providers to petition for reinstatement after two years of exclusion, we place a strenuous burden on them to prove that their readmission would be in the best interests of the program and its beneficiaries.

We believe the enactment of H.R. 1370 would prevent a sanctioned provider in one state from escaping the effects of that action by relocation to another state. Such action taken by the Secretary of Health and Human Services (HHS) would have nationwide ramification, thus substantially enhancing the deterrent effect of sanction actions taken by the individual states.

The enactment of H.R. 1370 would provide the further advantage of reducing the administrative burden on states of proving that a practitioner found guilty of improprieties in one state was also guilty of such transgressions in

another. The federal action of exclusion would provide the only evidence needed to take exclusionary action in all others.

We support those provisions of H.R. 1370 which would establish authority for the HHS Secretary to exclude from Medicare, and require states to exclude from Medicaid, any individual whose license to provide health care has been rendered ineffective by action of any state's licensure authority. Presently, existing individual state laws prohibit the practicing of a profession within a state in any circumstances in which the applicable professional license is not in force through revocation, suspension, or voluntary surrender. We view the import of H.R. 1370, therefore, as providing the same protections on a national basis. This would prevent a medical professional whose license has been revoked by one state from relocating to another state in order to escape the effects of the license revocation.

We also support the intent of H.R. 1091 which would authorize the HHS Secretary to impose civil monetary penalties on any licensed health care practitioners and providers who practice medicine under Medicare or Medicaid when he or she is not licensed, has obtained a license through misrepresentation or a material fact, or has misrepresented board certification in a specialty.

In summary, New York State is strongly committed to detecting and penalizing health care providers who abuse their public trust. We support these proposals for Congressional action which are aimed at enhancing the integrity of the public-supported health care programs through deterrence of fraud and abuse. Our support stems not only from a commitment to cost containment and to the fiscal integrity of the program, but also for the need to protect the health and safety of our citizens.

Attached is a draft of a New York State bill which seeks to protect New Yorkers from transgressors in other states. We believe a national Act would be far more effective and efficient, and would obviate the need for state-by-state legislative action.

DSS #30-85
David Emil, Deputy Commissioner and General Counsel

AN ACT to amend the social services law, in relation to the exclusion and removal of providers from participation in the medical assistance program

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The social services law is amended by adding a new section three hundred sixty-seven-e to read as follows:

I §367-e. Exclusion and removal of medical assistance providers. 1. The department
may exclude any individual or entity from current or future participation as a provider of
care, services or supplies pursuant to the medical assistance program, and, in the case of an
T individual who or entity which is currently participating as such a provider, may remove the
individual or entity from such participation, if such individual or entity is determined to be:

A (a) an individual or entity convicted under federal law or the law of any state of (i) an
act which if committed in this state would constitute fraud, theft, embezzlement, breach of
fiduciary responsibility, or other similar offense, or (ii) is based on the neglect or abuse of
any person; provided that such conviction is in connection with any program operated by or
L financed in whole or in part by any federal, state, or local government agency;

I (b) an individual or entity convicted under federal law or the law of any state of
unlawful manufacture, distribution, prescription, or dispensing of a substance that is a
controlled substance under the laws of this state;

C (c) an individual who has been authorized to practice or provide services as a medical
professional or in relation to the provision of medical care and whose authority is currently
suspended or revoked by the regulating agency of any state or who has relinquished such
authority for cause;

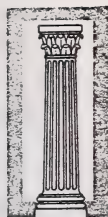
S (d) an individual or entity that the department determines has engaged in an
unacceptable practice, as defined in department regulation; or

(e) an individual or entity that otherwise fails to meet or fulfill the requirements for
participation in the medical assistance program, as set forth in department regulation.

2. Any individual or entity affected by a determination of the department made
pursuant to this section shall be given prior notice of said determination and, upon request,
shall be afforded a full evidentiary hearing before an administrative law judge of the
department, which shall be held no later than ninety days subsequent to the effective date
of the determination.

3. The department shall promulgate such regulations as may be necessary to
implement the provisions of this section. Nothing in this section shall be construed to
preclude the department, by promulgation of regulation, from establishing remedies for
unacceptable practices in addition to or apart from those of exclusion and removal, which
may be applied to individuals and entities described in subdivision one of this section.

§2. This act shall take effect on the one hundred twentieth day after it shall have
become a law.



**NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE**

1300 19th Street, N.W., Suite 310, Washington, D.C. 20036 (202) 822-9459

STATEMENT OF

FORMER CONGRESSMAN JAMES ROOSEVELT

CHAIRMAN OF THE

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

**PRESENTED TO THE
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH**

**AND THE
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
OF THE
UNITED STATES HOUSE OF REPRESENTATIVES**

REGARDING PROTECTIONS FOR MEDICARE PATIENTS

MARCH 29, 1985

It is time to protect Medicare beneficiaries from incompetent doctors and health care professionals who take financial advantage of the Medicare system. On behalf of its 1.2 million members, most of whom are Medicare beneficiaries, the **National Committee to Preserve Social Security and Medicare** urges these subcommittees and the Congress to pass the Medicare and Medicaid Patient and Program-Protection Act and the Medical Imposters Act.

It is a scandal when our senior citizens are robbed of the health care for which they paid. Health care needs increase with age and even with Medicare insurance, our seniors pay 15% of their income out-of-pocket for health care. The elderly, who live on limited retirement incomes, cannot afford to waste their health care dollars.

Doctors are now major financial beneficiaries of the Medicare program and the average net income of doctors is over \$100,000. Medicare beneficiaries rely on the competence and honesty of doctors and Medicare payments should only be made to doctors who care for our senior citizens competently and honestly. It is amazing that up to now Medicare hasn't had the authority to punish fraudulent doctors or ban them from the program.

These subcommittees, of course, are concerned about the Medicare financing crisis. Our members feel that sometimes the Congressional solution to the Medicare financing crisis is to "blame the victim" rather than the factors that contribute to the high cost of health care. Congress has cut Medicare benefits three times since 1981 and the administration proposes further cuts this year. Our members are angry and confused at these benefit cuts when they read about waste and fraud in Medicare and other government programs.

These two bills, by themselves, will not solve the Medicare financing crisis, but they are responsible efforts to attack the root of the problem. All our solutions to the Medicare financing crisis should keep in mind that Congress intended to make health care affordable for our senior citizens through Medicare insurance.

MEDICARE AND MEDICAID PATIENT
AND PROGRAM PROTECTION ACT OF 1985

SUMMARY OF MAJOR PROVISIONS

EXCLUSION OF CERTAIN INDIVIDUALS
AND ENTITIES FROM HEALTH CARE PROGRAMS

Mandatory Exclusion

The Secretary would be required to exclude from participation in medicare and to direct the State agencies to exclude from participation in medicaid, the maternal and child health program under title V, and the title XX social services, any individual or entity convicted of a criminal offense related to their participation under those programs. [Hereafter, medicaid, the maternal and child health program under title V, and title XX social services program will be referred to as the State health care programs.] The exclusion would be for a period not less than five years.

Permissive Exclusions

The Secretary would be permitted to exclude from participation in medicare and could direct the State to exclude from participation in a State health care program, any individual or entity convicted of:

1. fraud, theft, embezzlement, breach of fiduciary responsibility or any other offense related to financial abuse or neglect or abuse of patients;
2. interference or obstruction of any investigation into any criminal offense for which mandatory exclusion could be imposed or which is described in paragraph (1); or
3. unlawful manufacture, distribution, or dispensing of a controlled substance.

The Secretary would be permitted to exclude from participation in medicare and could direct the State to exclude from participation in a State health care program any individual or entity:

1. whose license to provide health care has been revoked, suspended by a State licensing authority or otherwise lost such a license for reasons bearing on professional competence, conduct or financial integrity;
2. who has surrendered such license while a formal disciplinary hearing was pending on the individual's or entity's professional competence, conduct or financial integrity; or
3. who has been barred or suspended from participation or otherwise sanctioned under any Federal program involving the provision of health care.

The Secretary would be permitted to exclude from participation in medicare and could direct the State to exclude from par-

participation in a State health care program any individual or entity determined by the Secretary to have:

1. knowingly or willfully made any false statement or representation for use in the application for payment under the above programs;
2. submitted requests for payment which contain charges substantially in excess of their customary charges;
3. furnished items or services substantially in excess of the patient's need or of a quality that fails to meet professionally recognized standards for health care; or
4. is a health maintenance organization, approved under medicare or medicaid, which has failed in a substantial number of cases to provide medically necessary items or services as required by law or contract.

The Secretary would be permitted to exclude any entity that has a person with an ownership or controlling interest, or who has an officer, director, agent or managing employee who has been convicted of certain program-related offenses, or against whom a civil monetary penalty has been assessed, or who has been excluded from participation in medicare or a State health care program.

The Secretary would be permitted to exclude any individual or entity which fails fully and accurately to make any disclosure required, or fails to supply to the Secretary as requested any information of any significant business transactions. In addition, the Secretary would be permitted to exclude any individual or entity that fails to provide information that the Secretary determines is necessary to determine amounts payable or refuses to permit examination of its fiscal or other records as may be necessary to verify such information.

The Secretary would be permitted to exclude an individual or entity which fails to grant immediate access to the Secretary, State agent, Inspector General or a State medicaid fraud control unit for the purpose of performing their statutory functions. The period of exclusion would be the period in which access was denied and an additional period not to exceed 90 days as set by the Secretary.

Procedure For Exclusion

The exclusion would be effective at such time and upon reasonable notice to the public and to the individual or entity as may be specified in regulations. Such exclusion would be effective on or after the effective date of the notice of such exclusion except that payment would be permitted under medicare or medicaid for up to 30 days for inpatient institutional services furnished to an individual admitted prior to the exclusion and for home health services or hospice care furnished pursuant to a plan established before the date of exclusion.

The notice of exclusion would be required to state the ear-

liest date on which the individual or entity could apply to the Secretary to be reinstated. The individual or entity excluded would be entitled to reasonable notice, an opportunity for a hearing, and judicial review of the Secretary's final decision.

The Secretary would be required to notify the appropriate State agency of the exclusion and require that they also exclude the individual or entity. The Secretary would be permitted to waive the exclusion from participation in a State health care program if the State agency so requests.

The Secretary would be required to grant an application for reinstatement if it is determined that no basis exists for continued exclusion and there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not and will not recur.

CIVIL MONETARY PENALTIES (CMPs)

The Secretary would be permitted to subject a person to civil monetary penalties for any claim which the person knows is false or fraudulent, including instances of double billing and submission of claims by doctors who had falsified medical credentials. In addition, the Secretary would be permitted to exclude such person from participation in medicare or in a State health care program. The Secretary would be permitted to use a single administrative and unified judicial review procedure for both the civil monetary penalty and the exclusion based on such penalty.

The Secretary would not be permitted to initiate an action under this section with respect to a claim later than six years after the claim was presented.

The Secretary would be permitted to issue and enforce subpoenas with respect to CMPs to the same extent the Secretary has such authority in other areas of medicare.

If it appears to the Secretary that any person has engaged, is engaging or is about to engage in any activity which would constitute a violation subject to civil monetary penalties, the Secretary would be permitted to enjoin such person from concealing or removing assets that could be required in order to pay a civil monetary penalty.

The State's share of funds collected under the CMP would be increased. The State would receive a portion of the total amount collected under the CMP in proportion to the State's participation in the original claim.

INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS

As a condition of approval of a medicaid plan, each State would be required to have a system of reporting information with

respect to formal proceedings concluded against a health care practitioner or entity by any State authority responsible for health care licensure.

The State would be required to report the following information to the Secretary (or under suitable arrangements made by the Secretary, to another entity):

1. any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license, reprimand, censure or probation;
2. any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State; or
3. any other loss of the license, whether by operation of law, voluntary surrender or otherwise.

The State would be required to provide the Secretary, or her designee, access to such documents as may be necessary to determine the underlying facts and circumstances of such actions and determinations.

The Secretary, or her designee, would be permitted to provide such information to licensing authorities and agencies administering State health care programs, utilization and quality control peer review organizations and State medicaid fraud control units in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of beneficiaries and to protect the fiscal integrity of such programs.

The Secretary would be required to provide suitable safeguards in order to ensure the confidentiality of such information as is not otherwise available to the public.

CONFORMING AMENDMENTS

MEDICAID AMENDMENTS - AUTHORITY TO EXCLUDE PROVIDERS

The State would be permitted to exclude any individual or entity from participation in a State medicaid plan for any reason which the Secretary could have excluded an individual from participation from medicare.

The State would be required, in order to receive payments for medicaid with respect to an entity furnishing services under a waiver (e.g. an health maintenance organization), to provide that it is willing to exclude any entity which could be excluded because of the provision relating to owners and managing employees who have been convicted of certain crimes or received other sanctions.

TERMINATION OF PROVIDER AGREEMENTS UNDER MEDICARE

A provider of services would be permitted to terminate an

agreement with the Secretary at such time and upon notice to the Secretary and the public.

The Secretary would be permitted to refuse to enter into an agreement, upon reasonable notice, or may refuse to renew or may terminate such an agreement after the Secretary:

- 1) determines that the provider fails to comply substantially with the provisions of the agreement or this title;
- 2) has been excluded from participation for certain offenses under this title; or
- 3) the provider has failed to take action to correct admissions patterns.

The termination or refusal to renew an agreement would be effective on the same date as an exclusion from participation.

EFFECTIVE DATES

In general, the amendments would be effective at the end of the 14 day period beginning on the date of enactment.

The provision which would require a minimum exclusion of five years would not apply to exclusions based on convictions occurring before the date of the enactment of this Act.

The effective date for changes in the medicaid law would be effective for calendar quarters beginning more than 30 days after enactment. In the case of a State plan which the Secretary determines would require State legislation in order to meet the additional requirements herein imposed, the State plan would not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

The subpoena and injunctive provision would be effective on the date of enactment.

MEDICARE AND MEDICAID SUPPORT OF MEDICAL EDUCATION

WEDNESDAY, APRIL 3, 1985

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will please come to order.

Today our subcommittee is holding a hearing on Federal support for training of health professionals under the Medicare and Medicaid Programs. We will be examining many facets of this very complex topic.

We want to establish a comprehensive understanding of medical education so that we can carefully evaluate the impact of the Medicare and Medicaid Programs on manpower policy and objectives.

We will want to consider what effects Medicare and Medicaid policies regarding medical education have on the availability and quality of patient care services, on the supply and distribution of physicians and other health professionals, and on hospitals providing essential services.

The amounts which Medicare and Medicaid spend on medical education represent only a small fraction of the total health care expenditures under those programs. However, the amounts are still very large in absolute terms and vastly exceed the amounts spent under the manpower programs for the Public Health Service Act.

Moreover, they have an enormous impact on how the rest of the health care dollars are spent and how they will be spent in the future.

Our hearing will not focus in depth on the health professions programs in title VII of the Public Health Service Act. However, we need to be aware of the objectives and status of those programs to fully understand the implications for Medicare and Medicaid.

Last year the President pocket-vetoed the reauthorizations for titles VII and VIII, and this year he has proposed to eliminate funding for them altogether. These programs have evolved and diminished over time so that they are now severely limited in their appropriations and sharply focused on specific manpower objectives.

In contrast, Medicare and Medicaid support for medical education is neither limited in amount nor designed to promote explicit manpower objectives. It is cost based and open ended. It reimburses teaching hospitals proportionately for whatever medical education they choose to provide, without regard to the impact on the supply and specialty distribution of physicians.

Many observers believe that the present arrangement, in fact, creates incentives that run counter to our national health manpower objectives.

The President's budget proposals include reductions in Medicare payments for medical education. The sum and substance of these proposals is simply to reduce the budget deficit. There does not appear to be any interest or recognition or concern about the implications of these reductions for patient care, for manpower objectives, for the financial well-being of the teaching hospitals, or for long-term cost effectiveness in the health care delivery system. Nor is there any recognition that policies in this arena cannot be changed abruptly without generating unnecessary disruptions and undesirable side effects.

We hope that this hearing will lay the foundation for a thoughtful analysis of Medicare and Medicaid policies regarding medical education.

To help us, we have received an excellent staff paper from the Congressional Research Service, which has been distributed to members of the subcommittee. That report will also be made a part of the hearing record.

[Testimony resumes on p. 208.]

[The report referred to follows:]



Washington, D.C. 20540

Congressional Research Service
The Library of Congress

FEDERAL FUNDING FOR HEALTH PROFESSIONS EDUCATION

Janet Lundy
and
Richard Price
Specialists in Social Legislation
Education and Public Welfare Division
April 3, 1985

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NOTE: This paper was prepared at the request of the Subcommittee on Health and the Environment, House Committee on Energy and Commerce.

INTRODUCTION

This paper provides an overview of Federal funding for health professions education. Included in this document is a discussion of:

- The nature of health professions education, including the training of physicians, nurses, and allied health personnel;
- Health professions education in the hospital setting;
- Sources of funding for health professions education, with special emphasis on Federal support under the Medicare program and the Public Health Service Act;
- Key issues concerning current and future financing for health professions education.

BACKGROUND

Health Professions Education

Health education programs for the training of physicians, nurses, and allied health personnel combine classroom training and learning through "hands on" experience. Classroom training is often conducted in a university setting and the "hands on" or clinical training is generally hospital-based.

Medical Education

Contemporary medical education (the training of physicians) generally includes the completion of four years of medical school and a residency program lasting three years or more. The four years of medical school education are often referred to as undergraduate medical education, even though most medical students enter medical school after completing four years of study at an undergraduate institution. Residency training, which begins after the completion of medical school and the award of the medical degree, is referred to as graduate medical education.

Typically, the first two years of undergraduate medical school training consist of classroom instruction in the basic sciences, including anatomy, biochemistry, physiology, pharmacology, and pathology. Most of this instruction is provided in the classroom at the medical school.

Although most students have at least some clinical experience during the first two years of medical school, the bulk of clinical training for the

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medical school student is provided during the last two years of undergraduate medical education. The length and number of required clinical education periods, known as clinical clerkships, vary from school to school. As part of a student's exposure to clinical medicine, clerkships are usually required in internal medicine, obstetrics-gynecology, pediatrics, psychiatry, and surgery. Clerkships vary in length from two to 12 weeks. During clerkships, students are usually assigned to a hospital service where they assume responsibility for assessing and presenting to the faculty a specified number of cases each week. Students also participate with post-M.D. trainees (residents) and faculty in caring for patients admitted to the clinical service to which they are assigned.

After completing undergraduate medical education and receiving the professional degree, most physicians enter graduate medical education programs, also known as residency training programs. Graduates of medical schools must enter residency training programs for a variety of reasons. First, most States require at least one year of graduate medical education to be eligible for a license to practice medicine. In addition, residency training is required for a physician to be certified as a specialist in a given area of medicine.

In 1984, there were approximately 75,000 residents in training in 4,800 approved residency training programs. Residency training programs are approved and accredited in one of two ways: (1) by the Accreditation Council for Graduate Medical Education (which is composed of representatives of the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Speciality Societies) upon recommendation of an appropriate residency review committee (RRC) which consists of representatives appointed by the American Medical Association, a particular specialty board,

and in some cases, a national specialty society; or (2) by the RRC itself if accreditation authority has been delegated by the Accreditation Council for Graduate Medical Education. Accreditation of a residency program indicates that it is in substantial compliance with published general requirements for graduate medical education and special requirements for training in a particular specialty.

Generally, residency training programs are offered by hospitals, and the resident is paid a stipend for participating (approximately \$20,000 per resident in 1984). However, in the course of completing a program, residents in some specialties such as preventive medicine, occupational health, and family practice may be assigned to clinics or ambulatory centers not associated with hospitals.

During residency training, knowledge and skills acquired in medical school are expanded through increasing personal responsibility for patient care in a structured and supervised clinical education environment. Residents in hospital-based graduate medical education programs, known as house staff members, provide care for patients, further their own education, and teach medical school students. As residents progress through their training programs, they gain considerable autonomy and responsibility for providing patient care services.

Residency training is organized by specialty (e.g., internal medicine, surgery, etc.). As noted above, for each of the approximately 25 medical specialties, various requirements have been established for residency training programs and for certification as a specialist upon completion of training. Training requirements include the content and length of residency programs. Residency programs vary in length according to specialty and typically last from 3 to 7 years. Specialties such as family medicine, internal medicine, pediatrics, and surgery encourage students to enter their residency training programs directly after completing medical school and to continue in these

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programs until they have completed specialty board requirements. Satisfactory completion of three years of training in family medicine, internal medicine, or pediatrics generally qualifies a doctor to sit for examination by the certifying boards of these specialties. Surgery requires five or more years of training depending on the subspecialty of surgery chosen.

Students seeking careers in other specialties are encouraged or required to spend their first graduate year in a residency program offering a broad clinical experience. Examples of these specialties are anesthesiology, dermatology, psychiatry, and radiology. Usually these students apply for a single year of internal medicine or for a diversified, traditional first graduate year with the expectation that they will enter a program in the specialty of their choice in their second graduate year. In some cases, a year of broad clinical experience may be located in the same institution where subsequent specialty training occurs. In other instances, specialty training must be completed elsewhere.

Foreign Medical Graduates

Graduates of foreign medical schools may participate in U.S. graduate medical education programs. These foreign medical graduates (FMGs), currently approximately 13,000, include (1) non-citizens who enter temporarily as exchange visitors for residency training and who return to their countries upon completion of training; (2) U.S. citizens who graduate from foreign medical schools; and (3) non-citizens who are admitted permanently as immigrants to the U.S.

The percent of FMGs in graduate medical education has dropped from its peak of 33 percent in 1970 to 18 percent in 1984. The 1976 Amendments to the Immigration and Nationality Act (P.L. 94-484) resulted in a decrease in the

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number of new exchange visitor physicians allowed to participate in residency training programs. In academic year 1973-74, more than 2,900 new exchange visitor physicians became eligible for residency training. In contrast, only 544 new exchange visitor physicians became eligible in 1981-82. Across all years of residency training, only 1,552 exchange visitor FMGs were in graduate medical education positions in 1981-82, as compared to over 8,000 in 1973-74.

Despite this decline, the number of U.S.-citizen FMGs (USFMGs) increased substantially. USFMGs in graduate medical education rose from 4,229 in 1979 to 7,314 in 1984. These figures reflect an increase of 73 percent in the number of USFMGs participating in graduate medical education. Proportionally, USFMGs represented about 35 percent of all FMGs in 1979 compared to 55 percent in 1984.

Nursing Education

Nursing education has evolved from what was once primarily three years of hospital-based training to several curricula which are becoming more closely affiliated with or sponsored by colleges or universities. While the classroom training is now more likely to be in a college or university, hospitals remain the primary sites for the undergraduate clinical training of nurses.

Three types of programs awarding different credentials prepare their graduates for licensing as registered nurses: diploma, associate degree, and baccalaureate degree programs. As of October, 1982, there were 1,432 State Board-approved programs of registered nursing education in the country.

Diploma programs, which generally are 3 years in length, are usually based in hospitals. Until the 1970's, the diploma program was the primary source of training for students to enter nursing and graduated the majority of registered

nursing students in any one year. The number of diploma programs has been declining steadily during the last two decades, as a result of demand by nurses for professional degree programs in institutions of higher education. In 1961, there were 875 diploma programs; as of October 1982, there were 288. Generally, students in diploma programs receive classroom instruction and spend three to four semesters in clinical training, which takes place most often in general care units of a hospital.

The newest of the three types of programs training registered nurses is the associate degree, primarily 2 years in length and located mainly in junior or community colleges. The first such programs were organized in the early 1950s, and their number continued to grow rapidly through most of the next decade. Starting in the early 1970s, the number of associate degree programs continued to increase but at a much lower rate than in their early developmental years. As of October 1982, there were 742 State Board-approved associate degree programs, compared with the 69 which existed in 1961. Generally, students enrolled in associate degree programs receive classroom instruction and spend three semesters in clinical training and, like diploma degree students, spend this time in general care units of a hospital.

The third type of program preparing students for licensure as registered nurses is the baccalaureate program. These programs generally require four years of study; however, a quarter of these programs are only two years in length since they first admit students in their junior year; another quarter are three years in length, admitting students to the program in their sophomore year; and half are four-year programs admitting students in their freshman year. While nursing programs leading to a baccalaureate degree have been in operation since the 1920s, the growth of these programs increased steadily beginning in

the 1960s and continuing throughout the next two decades. In October 1982, there were 402 baccalaureate programs, as compared with 173 such programs in 1961. Generally, students in baccalaureate programs spend four to five semesters in clinical training. Most of this training takes place in the hospital, including critical care units as well as general care units of the hospital. In addition, a significant portion of the clinical training of the baccalaureate student takes place in community health agencies, home health agencies, nursing homes, and other outpatient settings.

Basic nursing education provides a foundation for practice as a registered nurse. Advanced nursing positions (for example, clinical specialist, supervisory/administration, or teaching) require training beyond the registered nurse level. While the majority of nurses have not continued beyond their initial nursing education, about 13 percent, or 213,000 registered nurses, are estimated to have graduated from additional academic programs. These programs consist generally of classroom instruction as well as clinical training. The length and site of the clinical training for advanced nursing positions varies by program and specialty. For example, the clinical training of a clinical nurse specialist will often take place in the intensive care unit of a hospital. A family nurse practitioner, on the other hand, will spend little time in clinical training in the hospital (generally in the outpatient department), but rather will have a community agency or doctor's office as the principal site of clinical training.

In addition to training programs for registered nurses and advanced nursing positions, other programs prepare licensed practical nurses to provide nursing services under the supervision of a registered nurse or physician. As of October 1982, there were 1,295 State Board-approved programs preparing students

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to become licensed practical nurses. The majority of practical nursing programs are located in trade, technical, or vocational schools. About three out of ten are in junior or community colleges, while some are in hospitals and some in secondary schools. The number of programs located in hospitals has been declining; some 15 percent of programs in 1971 were in hospitals and only eight percent in 1981, the last year for which such data were available.

Allied Health Education

Allied health personnel include technologists, therapists, and others who perform relatively high-level health care functions, technicians and assistants whose duties vary greatly in complexity, and aides who perform routine supportive services. Allied health occupations include dietitians, physical therapists, speech pathologists, laboratory technicians, and nuclear medicine technologists. These, however, are only a few of many allied health occupations. One survey identified 141 health occupations that can be considered allied health by some definitions. The range of services rendered by allied health professionals includes emergency services, initial evaluation, treatment, therapy, testing, fitting of medical devices, record maintenance, acute care, long-term care, and rehabilitation.

Because of this variety in function, the scope of allied health education is similarly broad, ranging from limited postsecondary training to postdoctoral training. According to the 1984 Report to the President and Congress on the Status of Health Personnel in the United States by the Bureau of Health Professions, Department of Health and Human Services (DHHS), it is not possible with certainty to inventory all allied health training programs, academic and nonacademic, accredited and nonaccredited. However, this report estimates

that in 1979-80, there were approximately 475,000 students enrolled in allied health education programs in all settings, including collegiate and non-collegiate settings. A 1979-80 survey of collegiate allied health programs indicated that approximately 325,000 students were enrolled in allied health educational programs in collegiate settings. Only rough approximations of enrollments in programs in other institutions can be made: 65,000 in hospital-based programs, 40,000 in military programs, and 45,000 in other nonmilitary settings, such as vocational-technical or proprietary schools.

The length of a program a student must complete to qualify for entry into an allied health occupation varies by occupation. However, training for most allied health occupations follows the general model of classroom and clinical training. For collegiate programs, the most commonly used clinical facility is the hospital. However, many programs are affiliated with other settings; for example, programs for occupations with both a patient care and health promotion focus (dental hygienist and various types of therapists) tend to expose their students to a variety of settings outside the hospital.

Health Professions Education in Hospitals

Characteristics of Teaching Hospitals

Clinical training for both undergraduate and graduate health professions education in this country is generally conducted in the hospital setting. Approximately 18 percent of all U.S. hospitals offer teaching programs, which vary considerable in terms of their size and diversity. Teaching hospitals may have programs for the training of physicians (generally called graduate medical education, conducted through residency programs), nurses, or such

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allied health personnel such as dietitians, emergency medical technicians, occupational therapists, and physical therapists. The principal focus of this paper is on graduate medical education because these programs are the most costly for the teaching hospitals. In addition, very little data exist on the costs to hospitals of nursing and allied health programs.

The number of teaching hospitals in the country depends on the definition of teaching hospital used. Approximately 1,200 hospitals (18 percent of all U.S. hospitals) participate in at least one residency program. Approximately 1,100 of these hospitals are affiliated with medical schools. Approximately 400 of these teaching hospitals meet the requirements for membership in the Council of Teaching Hospitals (COTH) of the Association of American Medical Colleges, which include sponsorship of at least four approved residency programs ^{1/} and recommendation for membership by an accredited medical school with which the hospital is affiliated. Although data gathered by COTH from its members represent teaching hospitals with major graduate medical education programs and understate the number and variety of teaching hospitals in the country, little data about other teaching hospitals exist.

Major teaching hospitals are generally committed to at least three distinct objectives: 1) providing patient care, 2) training health professionals, and 3) conducting clinical research. The interrelationship of these three activities within the teaching hospital creates an institution which is in many ways different from the single purpose non-teaching hospital. This interrelationship also makes it difficult to separate the health professions education activities of a teaching hospital from its other activities, particularly

^{1/} That is, those accredited by the Accreditation Council for Graduate Medical Education or by the Residency Review Committee for the specific clinical specialty.

patient care. Each of these objectives of the teaching hospital is discussed in more detail below, using 1980 data from the COTH on its member hospitals.

Patient care. Most major teaching hospitals are large hospitals (75 percent of COTH hospitals had over 400 beds, compared to only 7 percent of non-COTH hospitals). Most COTH hospitals (75 percent as compared to 55 percent for non-COTH hospitals) are nonprofit entities located in urban areas (97 percent of COTH hospitals compared to 47 percent of non-COTH hospitals). COTH hospitals are concentrated primarily in the Northeast region of the country. Although COTH hospitals represented only 6 percent of all short-term non-Federal hospitals in 1980, they accounted for 18 percent of admissions, 21 percent of the births, and 30 percent of the outpatient visits. COTH hospitals on average employed almost six times the number of full-time equivalent personnel employed in non-COTH hospitals.

Teaching hospitals provide a wide range of hospital services, many of which (such as burn care units, organ banks, and open heart surgery) are typically unavailable in nonteaching community hospitals. Patients with the most severe medical problems tend to be referred to teaching hospitals for the latest techniques and equipment used in patient care. Teaching hospitals have historically played a major role in providing care for economically disadvantaged patients (COTH members admitted 18 percent of the country's patients but 25 percent of the Medicaid admissions) and had a higher-than-average share of patient bad debt and charity care (bad debt and charity care represented 9 percent of patient revenues in COTH hospitals in 1980 compared to 5 percent in non-COTH hospitals).

Clinical education. The teaching hospital is the setting for most of the clinical training for health professions in this country. According to

American Hospital Association data for 1983, U.S. hospitals provided training sites for approximately 71,000 medical and dental residents and for 9,000 other trainees, including nurses, technicians, and medical students in their last two years of medical school. In 1983, 1,200 hospitals had residency programs and 280 had professional nursing schools. In 1980, the 400 COTH hospitals trained 71 percent of all residents and 36 percent of all nursing and allied health trainees.

Historically, hospitals providing the opportunity for medical school graduates to gain practical experience were not affiliated with, or owned by, medical schools. Today, however, although free-standing residency programs may still be established, staffed, and controlled by an individual hospital, more commonly there exists some affiliation between the medical school and the teaching hospital. The term "academic health center" has been used to describe a constellation of institutions which provide undergraduate and graduate training in a variety of health professions. An academic health center can include medical schools, teaching hospitals, and often other professional and allied health schools, biomedical research institutions, ambulatory care centers, rehabilitation institutes, and health maintenance organizations. Although the affiliations between teaching hospitals and medical schools vary considerably, they emphasize the fact that the period of practical experience in a teaching hospital is considered an essential phase in the medical education of a physician.

Clinical research and applied technology. Many advances in the medical sciences began in the basic research laboratories of universities and their affiliated hospitals and were then applied to patient care in clinical research programs at teaching hospitals. While most of the nation's clinical research takes place in teaching hospitals, not all teaching hospitals are

equally involved in the medical research process. Generally, involvement in medical research projects is extensive where the hospital's medical staff is composed primarily of full-time faculty physicians. Medical research is typically less extensive where the hospital's medical staff is composed of physicians in private practice. A major commitment on the part of a teaching hospital to medical research results in certain managerial and financial implications for the hospital. For example, research programs often alter the mix of services and the cost of care for patients in experimental care programs in teaching hospitals compared to non-teaching hospitals.

Measuring the Cost of Health Professions Education in Hospitals

The costs of delivering patient care in teaching hospitals are consistently higher than in non-teaching hospitals. Simple cost comparisons, for example, show that in 1981 the average cost of care in COTH hospitals was \$3,281 per adjusted admission, nearly twice as high as the average of \$1,683 in non-COTH hospitals. These cost differences reflect many of the differences in objectives and other characteristics (such as location and size) between teaching and non-teaching hospitals which were described earlier in this paper.

Teaching hospitals incur additional costs because of their educational activities: faculty, support staff, and residents must be paid; conference and classroom space must be included in the hospital plant; and additional equipment and supplies must be purchased. The costs of these activities, known as the direct costs of health professions education, are generally identifiable and separable by standard accounting methods from the costs of patient care in the hospital. The direct costs of graduate medical education have been estimated to be between \$1 and \$3 billion nationwide. The average amount that a COTH member hospital spent on resident stipends and benefits in 1983-1984

was \$3.2 million, or approximately 4 percent of the average COTH hospital's total operating budget.

In addition to the direct costs of medical education, the presence of teaching activities can indirectly affect a hospital's costs. These indirect costs can arise from reduced productivity in patient service departments (e.g., treatment takes longer, demands on other staff are greater), increased overhead for such activities as the keeping of medical records, increased complexity of hospital management, and the tendency of residents to provide more services and to conduct more tests than experienced licensed physicians.

In addition, there are other factors that may account for the cost differences between teaching and non-teaching hospitals which may not be directly related to the teaching activity. These factors, which are not currently separable from the indirect costs of medical education, may include patients who are more severely ill, clinical research, more sophisticated and expensive medical technology (with perhaps the added cost of "idle" time or "standby" capacity for infrequently used services), higher and more specialized staffing levels, and perhaps less efficient operation. Many of these factors are related to differences in the complexity of the mix of patients (known as case mix) treated and the diversity and sophistication of the services offered in teaching hospitals versus non-teaching hospitals, rather than to the actual teaching activity itself.

The indirect costs of health professions education in teaching hospitals are difficult to separate from total operating costs and to quantify because patients are being treated and students are being trained through the same patient care activities. Although data show that teaching hospitals have costs per admission that are twice as high (100 percent higher) as those in

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non-teaching hospitals, few studies have attempted to account for this difference. The direct costs of health professions education programs account for only approximately 10 percent of the difference in costs between teaching and non-teaching hospitals. Thus, approximately 90 percent of the difference remains to be accounted for. Due to the limited analyses of indirect medical education costs, it is unclear whether the remainder can be attributed to the indirect costs of the medical education activity or must be attributed to other characteristics of the teaching hospital.

Some studies have suggested that indirect costs may be quite large. For example, as part of a study on the Financing of Medical Education conducted by Arthur Young and Policy Analysis, Inc., for the Department of Health and Human Services, total costs per admission were analyzed for patients in four diagnostic categories at seven teaching and two non-teaching hospitals. A 1983 pilot report from this study indicated that, on average, the direct and indirect costs of graduate medical education accounted for more than 40 percent of the costs per admission in the teaching hospitals studied. Most of the observed difference in cost was attributed to the indirect costs of graduate medical education, primarily the greater use of ancillary tests and procedures. Further analysis of a subset of patients for whom severity of illness had been measured indicated, however, that some portion (but not all) of the difference might be attributed to differences in severity of illness. Other studies have shown a wide range of results in estimating the contribution of indirect teaching costs to total costs in teaching hospitals. Due to the limitations of the available studies, however, the size of indirect costs remain unclear. Results from the Arthur Young study, to be completed later this year, should be helpful in this analysis.

Another study of graduate medical education underway is that commissioned by the Commonwealth Fund Task Force on Academic Health Centers. The study has three components: the Future Financing of Teaching Hospitals (using secondary analyses of existing data); the Size, Content and Cost of Graduate Medical Education Programs; and the Role of Teaching Hospitals in the Care of the Poor and the Uninsured. This study should be completed this summer.

Using broad estimates from several sources, the total costs to hospitals of their graduate medical education activities range from \$4 to \$9 billion nationwide, with \$1 to \$3 billion estimated for direct costs and \$3 to \$6 billion for indirect costs. These amounts represent approximately one percent to two and one-half percent of the \$355 billion spent nationally for health in 1983. Although these numbers represent the major portion of hospital costs for health professions education in this country, they understate total spending to the extent that they exclude the costs of nursing and allied health programs, for which data are not available.

Sources of Financing for Health Professions Education

Overview

A variety of sources exist for financing health professions education. For undergraduate medical education, support is available for student assistance, primarily through Federal loans and loan guarantees, and Federal and private scholarships. Medical schools receive financial support from Federal research awards, State and local government appropriations, the professional fees generated by faculty members from their patient care activities, and Federal grants available under the Public Health Service Act for special

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education and training programs. Teaching hospitals receive support for health professions education programs primarily through revenues received for patient care.

Student support. Undergraduate students receive support from the following sources:

Non-borrowing (the source for 12% of medical school seniors in 1984)

- ° Personal or family resources
- ° Service contingent scholarships, including Armed Forces and National Health Service Corps, and State and other scholarships
- ° Other scholarships, including school funds

Borrowing (the source for 88% of medical school seniors in 1984)

- ° Private sources with Federal guarantees, including the Guaranteed Student Loan Program and Health Education Assistance Loans
- ° Matching revolving funds, established jointly with Federal and school resources, including Health Professions Student Loans and National Direct Student Loans
- ° School loan funds
- ° Private conventional loans

Support for medical schools. Medical schools receive support from both government and non-government sources to operate programs in education, research, and patient care. Federal research awards are a major source of revenue (approximately 20 percent of total medical school revenues). Other sources of Federal support (5 percent) include awards for training, education, and service programs (for example, those available under the Public Health Service Act). Public medical schools derive a substantial amount (36 percent) of their revenues from State and local government appropriations (only 4 percent for private medical schools). Tuition and fees account for about

6 percent of medical school revenues. The remaining identifiable portion of revenues comes from medical service revenues (40 percent for private medical schools and 26 percent for public medical schools), which come primarily from the professional fees generated by faculty members from their patient care activities.

Support for teaching hospitals. Patient care revenues are the primary sources of support for both patient care activities and health professions education programs in teaching hospitals. For example, according to 1983-1984 data on COTH member hospitals, 81 percent of the costs of residency stipends and fringe benefits were derived from patient care revenues. Other sources included State appropriations earmarked for residency expenses (5 percent), Veterans Administration appropriations (2 percent), medical school/university funds (2 percent), municipal appropriations earmarked for residency expenses (1 percent), and physician fee revenues (1 percent). Foundation grants and voluntary agencies, NIH, other Federal agencies, endowment income, and other sources of support made up the remaining 8 percent of total residency support in teaching hospitals.

Support of health professions training in hospitals through patient care revenues has historically been considered appropriate since such training is produced jointly with patient care. Teaching hospitals have routinely included the costs of these training programs along with their other expenses in determining their total costs of producing hospital services and in setting their charges for services. These costs also have been included in the rates paid for patient care by payers of hospital services (known as third-party payers), including Medicare, Medicaid, Blue Cross, and the commercial health insurers. Health professions education in hospitals has thus been subsidized by the third-party payers, who obtain their funds for patient care payments from employer/employee payroll taxes (Medicare), Federal and State tax revenues

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(Medicaid), and employer/employee/enrollee premium payments (Blue Cross and commercial insurers).

Medicare Payments for Health Professions
Education in Hospitals

Since its inception, the Medicare program has recognized in various ways in its reimbursements to hospitals certain expenses associated with the operation of approved health professions education programs. Although not required by law, congressional intent indicated that the Medicare program should pay its share of the net cost of education activities conducted in hospitals until the community undertakes to cover these costs in some other way:

Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program. ^{2/}

Medicare regulations (CFR, Title 42, Sec. 405.421) indicate that a provider's (e.g., a hospital's) allowable costs for purposes of Medicare reimbursement may include the net cost of approved educational activities. Net cost is defined as a provider's total direct and overhead costs of approved educational activities (including trainee stipends, compensation of teachers and other direct and overhead costs, minus revenues the provider receives from tuition.

^{2/} U.S. Congress Senate. Social Security Amendments of 1965. Report of the Committee on Finance to accompany H.R. 6675 to Provide a Hospital Insurance Program for the Aged . . . June 30, 1965. Washington, U.S. Govt. Print. Off., 1965. (98th Cong., 1st Sess. Senate Rept. No. 404, Part I), p. 36.

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Approved education activities are defined by regulation as formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law; where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity. Approved programs include medical, osteopathic, dental, and podiatry internships and residency programs, recognized nursing programs, and allied health education and training programs including cytotechnology, dietetic internships, hospital administration residencies, inhalation therapy, medical records, medical technology, nurse anesthetists, professional nursing, practical nursing, occupational therapy, pharmacy residencies, physical therapy, and x-ray technology.

Payment Under Cost-Based Reimbursement. When the Medicare program began in 1966, Medicare paid its proportional share of a hospital's health professions education costs together with other allowable costs under Medicare's cost-based method of reimbursement. Over the years, as the Medicare program began to establish limits on the amounts it paid to hospitals, the costs of medical education received special consideration.

Under authority contained in Section 223 of the Social Security Amendments of 1972, the Department of Health and Human Services (then the Department of Health, Education and Welfare) began in 1974 to establish annual cost limits on reimbursement of certain routine hospital costs (generally, the costs of room, board, and routine nursing care). The higher routine costs of hospitals with significant medical education activities were recognized by the Medicare program in 1975 when an exception to the routine hospital cost limits was allowed if a hospital could demonstrate that it exceeded its cost limits

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because of the costs of its educational activities, to the extent that such costs were atypical compared to those of other similar hospitals.

Explicit allowance was made for medical education costs, effective with hospital cost reporting periods which began July 1, 1979, when the direct costs of approved medical education programs were excluded from the routine costs subject to the Medicare hospital cost limits. The direct medical education costs were excluded so that the basis on which the cost limits were applied in teaching and non-teaching hospitals would be comparable.

On April 1, 1980, the Department proposed that an additional adjustment for the indirect costs of medical education programs be made to Medicare's hospital routine cost limits. The proposed regulations stated that:

Generally, hospitals with approved graduate medical education programs incur higher per diem operating costs than non-teaching hospitals of similar bed size and geographic location We believe these increases in per diem cost occur because the provision of graduate medical education causes increases in certain types of costs that are only indirectly related to education programs. . . . To prevent a disproportionate number of teaching hospitals from being adversely affected by the limits, we have, in the proposed schedule, provided an automatic adjustment for the costs generated by approved medical education programs. Based on the data we used to derive the proposed limits, we have estimated that a hospital's general inpatient routine operating costs may be expected to increase by a factor of .047 (4.7 percent) for each increase of .1 (above zero) in the ratio of its full-time equivalent (FTE) interns and residents (in approved programs) to its number of beds. 3/

It should be noted that the proposed regulations stated that to obtain this adjustment, a teaching hospital would not be required to identify explicitly the costs for which the adjustment was being made. Instead, the hospital would be required to report only its number of full-time equivalent interns and residents in approved programs (i.e., those employed more than 35 hours or more

3/ Federal Register, April 1, 1980, p. 21584.

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per week and one-half of those employed less than 35 hours per week in the hospital) which, together with the hospital's bed size, would be used to compute the percentage by which the hospital's reimbursement limit would be increased. This medical education adjustment, which later became known as the indirect medical education adjustment, became effective for hospital cost reporting periods which began on July 1, 1980.

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248, known as TEFRA) made certain changes in the hospital routine cost limits, including expansion of the limits to cover total inpatient operating costs (not just routine costs) so that ancillary and special care unit costs were included. Because more of a hospital's costs were now included under the limits, the limits effective for hospital cost reporting periods beginning on October 1, 1982, included an increase in the percentage amount of the indirect medical education adjustment from 4.7 percent to 6.06 percent.

TEFRA also created a new ceiling on the allowable annual rate of increase in total inpatient operating costs per case for inpatient hospital services. As with the hospital cost limits, these new rate-of-increase limits excluded the direct costs of approved health professions education programs.

Payment Under the Prospective Payment System. Title VI of the Social Security Amendments of 1983 (P.L. 98-21) established a new method of hospital payment by the Medicare program, known as the Prospective Payment System (PPS). Effective for hospital cost reporting periods that began October 1, 1983, the Medicare program has been paying hospitals, with certain exceptions, according to predetermined rates for each of 468 Diagnosis Related Groups (DRGs), rather than on a cost basis. The prospective payment legislation and regulations,

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however, continue to provide for special treatment of direct and indirect medical education costs.

Direct medical education costs under PPS. The direct costs of medical education in hospitals are excluded by law from the Prospective Payment System and are paid for separately on the basis of reasonable costs. In its December 1982 report to Congress proposing a hospital prospective payment system for Medicare, the Department favored excluding the direct costs of approved medical education programs from the prospective rates and reimbursing them on the basis of reasonable costs. As stated in the report: "This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital. This approach will allow for continued Federal support of medical education through the Medicare program while clearly identifying that support as separate from patient care." 4/

Indirect medical education costs under PPS. P.L. 98-21 requires that additional payments be made to hospitals for the indirect costs of medical education, computed in the same manner as the adjustment for indirect medical education costs was calculated under the Medicare hospital cost limits, except that the educational adjustment factor would be doubled. The Senate Finance Committee report on the Social Security Act Amendments of 1983 indicates that the adjustment for indirect medical education costs is only a proxy to account

4/ U.S. Department of Health and Human Services. Report to Congress. Hospital Prospective Payment for Medicare. Dec. 1982, pp. 47-48.

for a number of factors which may legitimately increase costs in teaching institutions. The report also states:

This adjustment is provided in the light of doubts (explicitly acknowledged by the Secretary in his recent report to Congress on prospective payment) about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents. The latter costs are understood to include the additional tests and procedures ordered by residents as well as the extra demands placed on other staff as they participate in the education process.

The committee emphasizes its views that these indirect teaching expenses are not to be subjected to the same standards of "efficiency" implied under the DRG prospective system, but rather that they are legitimate expenses involved in the post-graduate medical education of physicians which the medicare program has historically recognized as worthy of support under the reimbursement system. 5/

As provided in Medicare regulations, the payment for indirect medical education costs equals 11.59 percent of the Federal portion of a hospital's prospective payment for every 0.1 full-time equivalent (FTE) intern or resident per bed. Regulations defined the number of FTE interns and residents to be the sum of the number of interns and residents employed by the hospital for 35 hours or more per week, plus one-half of the number of interns and residents working less than 35 hours per week. For cost reporting periods beginning on or after October 1, 1984, interns and residents are not required to be employees of the hospital in order for the hospital to qualify for the indirect medical education adjustment. Hospitals are now required to document each intern or resident providing services at the facility by name and Social Security number and the number of hours the intern or resident works at that hospital.

5/ U.S. Congress. Senate. Social Security Amendments of 1983. Report to Accompany S. 1. March 11, 1983. Washington, U.S. Govt. Print. Off., 1983. (98th Congress, 1st Session. Senate Rept. No. 98-23), p. 52.

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Other provisions for teaching hospitals under PPS. In addition to the explicit provisions in the prospective payment legislation for direct and indirect medical education costs, provisions relating to payments for atypical cases also benefit teaching hospitals. Both the Finance and the Ways and Means Committee Reports indicate that the provision of additional payments for atypical cases which have either extremely long lengths of stay or extraordinarily high costs (known as "outliers") would benefit teaching hospitals since the committees believed it reasonable to expect that such cases would occur more commonly in teaching hospitals than in other hospitals.

Cost to Medicare of Health Professions Education in Hospitals.

The Report of the 1982 Advisory Council on Social Security (December 31, 1982) states that historically, expenditures for the education and training of health professionals have represented between 4 and 6 percent of annual Medicare Health Insurance (HI) Trust Fund expenditures. The Report indicates that in 1980, the HI Trust Fund spent an estimated \$1.4 billion for the direct and indirect costs of medical education programs; for 1983, the estimate is \$1.8 billion; for 1987, \$2.8 billion is estimated.

More recent estimates from the Health Care Financing Administration presented at the April 3, 1985, hearing on Federal support for medical education held by the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, indicate that Medicare expenditures for health professions education will total approximately \$2.7 billion in FY86, \$1.3 billion for direct costs and \$1.4 billion for indirect costs. Medicare is the single largest payer for health professions education in hospitals, contributing approximately one-third of the total.

Medicaid Payments for Health Professions Education in Hospitals

Medicaid is a federally aided, State-operated and administered program of medical assistance for low-income persons. Until the passage of P.L. 97-35 (the Omnibus Budget Reconciliation Act of 1981), States were required to reimburse hospitals on a reasonable cost basis as defined by Medicare. Under reasonable cost reimbursement, the direct and indirect costs of health education programs were included by hospitals in their total reasonable costs, which were then reimbursed by the State Medicaid programs for services provided to Medicaid recipients.

P.L. 97-35 gave States considerable leeway in establishing the method and level of hospital reimbursement of their choice, within certain broad Federal requirements. Approximately half the States are still using the former reasonable cost-based method of reimbursing hospitals or a variation derived from reasonable costs as formerly defined by Medicare. Although no studies exist on Medicaid payments for health professions education costs, presumably in these States the costs to hospitals of health professions education programs are being reimbursed either as a reasonable cost or as a component of the base on which a variation of reasonable cost reimbursement is built.

Other States have established alternative Medicaid hospital reimbursement systems, including prospective payment systems which apply to all payers for hospital care in the State (Maryland, Massachusetts, New Jersey, and New York), prospective payment systems using diagnosis related groups (Michigan, Ohio, Pennsylvania, and Utah), and other types of hospital payment systems, including contracting with individual hospitals (Arizona and California). Some of these systems specify how medical education costs are to be treated. In general, it appears that direct medical education costs are either passed through and reimbursed on a reasonable cost basis or they are included in a per diem or per admission rate paid to the hospital. The indirect costs are

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generally not treated separately but are implicitly included in the total rate paid to a hospital.

The Health Care Financing Administration has indicated that a rough estimate of total FY86 Medicaid payments for direct medical education is \$400 million of which the Federal share would be \$250 million. No estimates are available on Medicaid payments for indirect medical education.

Health Professions Education Under the Public Health Service Act

Medical Education--Title VII of the Public Health Service Act--Background. During the recent past, there has been a rapid and large increase in the number of physicians in the country. In 1950, there were approximately 220,000 M.D.s in the U.S., representing a ratio of 134 physicians per 100,000 population. In the mid-1960s, concern was expressed about shortages of physicians and other health professionals in the nation. Efforts were supported to create more medical schools, increase class sizes in medical schools, and ease restrictions on the influx of foreign medical graduates into the country. Consequently, by 1975, the number of M.D.s in the country had increased to 393,742, for a physician ratio of 179 per 100,000 population. This number further increased, as reflected in American Medical Association (AMA) data, to 501,958 physicians in 1982, resulting in a physician-to-population ratio of 213 per 100,000.

In the 1960s and through 1970, a number of reports attested to the seriousness and scope of health personnel shortages. As late as 1970, the Carnegie Commission on Higher Education stated in a report: "The most serious shortages of professional personnel in any major occupation group in the United States are in health services." Among other things, the Commission recommended a 50 percent increase in first-year enrollments at medical schools to help eliminate a shortage of some 50,000 physicians.

In order to alleviate shortages, Congress established in 1963 in title VII of the Public Health Service Act programs of direct Federal support for health professions education. Direct Federal support became available for programs designed to increase enrollments and graduates of health professions schools. These programs were significantly expanded in several ways during the next decade. First, Congress expanded the number of programs and schools eligible for support. During this period, there were established construction grant programs; formula grant programs based on the number of students enrolled (these would later be called capitation grants); and a broad range of special project grant programs to encourage schools to undertake certain activities such as primary care training, curriculum development, and programs for disadvantaged students. At first, schools of medicine, osteopathy, and dentistry were the only schools eligible for this assistance. Later, as Congress revised and extended title VII programs, eligibility was expanded to include schools of veterinary medicine, optometry, podiatry, pharmacy, allied health, public health, and graduate programs in health administration.

There were also various student assistance programs enacted: scholarship programs and loan programs were established, as well as the National Health Service Corps scholarship program. Under this latter program, students who receive scholarship assistance are then obligated to practice in a health manpower shortage area.

Congress also, during the period 1963-73, significantly expanded the level of Federal funding for these various programs. For title VII programs, an authorization level of \$30.1 million in FY 1964 grew to an authorization level of \$1.1 billion and appropriations of \$483 million 10 years later in FY 1974.

When in 1974 the Congress began to consider revision and extension of health manpower training programs, the need to increase the aggregate supply of

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health personnel no longer commanded the attention and concern it had in prior years. This was, in part, the result of an awareness that Federal support had provided substantial increases in enrollments at health professions schools. For example, first-year enrollments at medical schools increased from 8,772 in 1963-64 to 14,159 in 1973-74. Today, that number is over 16,000.

In addition, in 1974 there were the very first suggestions that the aggregate supply of health professionals would be sufficient in the near future. During hearings before the Congress in 1974, the Assistant Secretary for Health of the Department of Health, Education, and Welfare estimated that by 1980, the nation's supply of physicians would likely be adequate to meet projected requirements for physician manpower.

Instead of supply considerations, observers pointed to problems associated with the specialty and geographic maldistribution of health professionals. The nation still lacked health personnel in many rural and inner-city areas. In addition, there were thought to be too many surgeons, neurologists, radiologists, and other specialists, and not enough primary care physicians. For the first time, Congress also perceived that health professionals could assume more of the costs of their education, since their education provided them with potentially high-paying careers.

Thus, when Congress concluded consideration of the extension of title VII programs in 1976, it had begun the process of refocusing institutional assistance on special projects which would encourage health care personnel to practice in medically underserved areas, which would increase the number of primary care practitioners, and which would support other national objectives. In addition, beginning in 1976, Congress also limited financial assistance for students. For example, health professions scholarships were phased out and replaced with a more limited scholarship program for first-year students with exceptional

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financial need. Revisions in 1976 also included limiting additional Federal support for the Health Professions Student Loan Program, with its government-subsidized interest rates. To supplement this program, Congress established a new Health Education Assistance Loan program, under which health professions students secure loans at prevailing market interest rates from private lenders, and these loans are guaranteed by the Federal government.

In 1980, as Congress began again to consider revision of expiring title VII programs, the Department of Health and Human Services-chartered Graduate Medical Education National Advisory Committee (GMENAC) issued its findings on the supply and requirements for physicians in the 1990s. GMENAC estimated that by 1990, there would be a surplus of 70,000 physicians in the country, and by the year 2000, this surplus would increase to 145,000.

When Congress concluded revision and extension of title VII health professions programs in 1981, it extended the authorities through FY.1984. With findings such as GMENAC's, Congress continued to focus title VII support on special training programs which attempt to address problems of health personnel geographic and specialty maldistribution, while ending support for authorities designed to increase graduates from schools where supply was expected to be adequate. At this time, Congress repealed the authority of capitation grants for all health professions schools, except for schools of public health. As noted earlier, capitation grants were established to encourage health professions schools to increase enrollment.

As the result of changes in the objectives for Federal support for health professions education, funding for title VII programs began declining in 1974. In FY 1981, funding for title VII programs amounted to \$176 million and has fallen to \$143 million in FY 1985.

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Current Funding for Title VII Programs. Since its first authorization 22 years ago, title VII support has shifted from its original emphasis on increasing, in the aggregate, the nation's supply of health manpower toward directing available support to programs which are intended to address specific problems, such as the geographic and specialty maldistribution of health personnel. Today title VII funds, among other things, a number of special purpose projects, including primary care training programs; programs to provide training opportunities for students in underserved areas that are geographically removed from the main site of a health professions school (the Area Health Education Center program); a variety of curriculum development projects, including geriatric training projects; public health and health administration training; and programs to identify, recruit, and enroll minority and economically disadvantaged students wishing to pursue health careers.

One of the major areas of title VII support in recent years has been primary care training, with assistance provided for (1) the establishment of family medicine departments in medical schools; (2) residency training programs in schools and hospitals for family medicine and general dentistry; and (3) residency training programs in schools and hospitals for general internal medicine and pediatrics. Of the \$143 million appropriated for title VII programs in FY 1985, \$62 million, or 43 percent, was provided for these three programs. According to the Bureau of Health Professions in the Department of Health and Human Services, a breakdown of grants made in FY 1984 to schools and hospitals under the latter two of these programs shows that, for family medicine residency training, hospitals received \$9.4 million (average award \$133,372) and schools (medical and osteopathic) received \$10.3 million (average award (\$117,571). For general internal medicine and pediatrics training in FY 1984, hospitals received \$2.7 million (average award \$176,733) and schools (medical and osteopathic) received \$11.9 million (average award \$201,136).

Congress has funded primary care programs in order to encourage training opportunities in such fields as family medicine, internal medicine, and pediatrics. It has been noted that, compared with other specialty training programs, primary care programs receive less revenue from patient care services and research grants and loans and thus have greater difficulty in financing their costs. Approximately 39 percent of professionally active M.D.s are in the primary care specialties of family practice, internal medicine, and pediatrics. In 1982, the ratio of primary care physicians per 100,000 population stood at 74, compared with 117 per 100,000 population for all other medical and surgical specialties. Since 1970, the ratio of primary care physicians per 100,000 population has increased from 56 to 74 in 1982, or by 32 percent. For all other medical and surgical specialties, this ratio has increased from 92 to 117 per 100,000, or by 27 percent.

Congress has provided support for a number of programs which are intended to address problems associated with the geographic maldistribution of health professionals. These programs, such as Area Health Education Centers (AHECs) and primary care training programs (including physician assistants training programs), are intended to provide incentives for health professions schools to establish and operate training programs which might ultimately increase the number of health personnel practicing in medically underserved areas. The AHEC program, in part, establishes training opportunities for students in underserved areas that are geographically removed from the main site of the health professions school. In addition, studies have indicated that primary care specialists, especially general family practitioners, tend to establish their practices in medically underserved areas more often than other specialists. Thus, increasing the nation's supply of primary care physicians is one way of improving access to health care in previously unserved or underserved areas.

Various studies have been conducted which focus on the dynamics of the geographic distribution of health professionals. Three recent Rand Corporation studies have found that physicians were increasingly locating in less-densely populated areas, thereby indicating that market forces were alleviating problems in the geographic distribution of physicians.

However, other studies have found that counties with the lowest population and smallest numbers of physicians relative to population have been showing relatively little improvement in physician density. Such areas will continue to be economically unattractive for physicians, especially when reimbursement practices and the ability of physicians to determine the quantity of medical services provided to consumers support new physicians in well-served areas despite shortages elsewhere.

Nurse Training - Title VIII of the Public Health Service Act. Nurse training programs authorized under title VIII of the Public Health Service Act have provided Federal support for nursing schools and students since 1964. Congress consolidated and expanded programs of support for nurse education in title VIII in response to perceived shortages of professional nurses in the country. When originally enacted, title VIII provided Federal support which was intended principally to increase the aggregate supply of registered nurses in the country. It did so by encouraging nursing schools to increase their enrollments and graduates. In 1964 there were 550,000 registered nurses in the country; today there are approximately 1.6 million.

As supply increased, Federal support for title VIII has been reduced. In 1980, \$100.3 million was appropriated for title VIII programs. In 1985, \$50.3 million was appropriated. In addition, available support has shifted its emphasis from increasing the aggregate supply to targeting support on special education

programs which, among other things, train nurses to receive advanced degrees and for specific roles in the nursing profession.

A 1983 Institute of Medicine study found that, while in the aggregate there is not a significant national shortage of generalist registered nurses, shortages do occur unevenly throughout the nation in different geographic areas, in different health care settings (especially those that serve the economically disadvantaged), within institutions, and in specialty nursing.

Today, title VIII supports a special projects program which has among its purposes (1) improving the supply and distribution of nurses in geographic areas, in the various specialties of nursing, and in health care institutions; (2) recruiting and retaining minorities and economically disadvantaged individuals in schools of nursing; and (3) strengthening curriculum in areas such as geriatric and long-term care, health promotion, and disease prevention.

It also provides support for advanced nurse training programs which train nurses to become teachers or nurse specialists, or to serve in administrative or supervisory capacities. Observers have noted that since the establishment of title VIII, the demand for nurses with advanced degrees has continued to be greater than the ability of schools to prepare nurses of advanced levels to work as teachers, clinical specialists, administrators, and supervisors.

Title VIII also provides support for the training of nurse practitioners. Nurse practitioners receive advanced training to provide primary care services without the immediate supervision of a physician and often do so in medically underserved areas. Studies have indicated that nurse practitioners provide cost-effective care and increase the productivity of medical practices.

Payments by Private Payers for Health Professions Education

Since teaching hospitals have historically included the costs of health professions education in their total costs and their charges for patient care, the private payers for hospital services (including Blue Cross, commercial health insurers, prepaid health plans, and private paying patients) have traditionally financed such activities through the payments they make for patient care.

The Blue Cross and Blue Shield Association's 1978 Policy Statement on Payment to Health Care Institutions states that ". . . the cost of community services, such as research and education, should be borne primarily by the community with participation by purchasers occurring only after negotiation." Since medical education benefits society as a whole, the costs associated with medical education are considered the responsibility of the community. The Blue Cross plans generally are expected to obtain medical services for their subscribers at the best possible price. Additional costs above those required to pay for necessary and reasonable medical services are to be paid only after negotiation with the parties involved. However, historically, Blue Cross plans have paid for health professions education costs in the context of paying hospitals their costs or charges for patient care services.

The higher cost of care at teaching hospitals compared to non-teaching hospitals puts them at a disadvantage as various private payers begin to make changes in their payment methods in order to control costs. Such payment changes include paying a prospectively-established fixed rate for patient care, and negotiating contracts with hospitals offering a lower price than their competitors (i.e., a preferred provider organization, or PPO). The higher costs of teaching hospitals may mean that under fixed-price payment systems they

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will not be paid as large a percentage of their costs as will lower-cost non-teaching hospitals. Or it may mean that under negotiated payment schemes, teaching hospitals will not be able to compete with lower-cost non-teaching hospitals for contracts.

ISSUES

A broad range of important issues have been raised about the effects which current Medicare and Medicaid payment policies for health professions education have on patient care, on the supply and distribution of physicians and other health professionals, on the institutions providing such education, and on the costs of the programs. Similar questions need to be addressed in considering any changes in current Medicare and Medicaid policies. Some of these issues are identified and described below.

Should Medicare and Medicaid Continue to Pay for Medical Education Costs?

Some people question whether the Medicare and Medicaid programs, which were designed to pay for medical services to Medicare and Medicaid beneficiaries, should continue to underwrite the cost of medical education through their payments to hospitals. For example, in view of its perception of a financial crisis facing the Medicare program, the 1982 Advisory Council on Social Security recommended that Medicare's support for medical training be withdrawn as other sources of support are identified. Others have argued that Medicare's Hospital Insurance Trust Fund is an inappropriate source of medical education subsidy because those who benefit (primarily doctors) will generally earn incomes much higher than the employees who pay the Medicare payroll tax. Still others question whether Medicare should continue to make money available for medical education when there appears to be an adequate supply of physicians and other health care professionals except in a few areas of targeted Federal

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support, such as primary care. Finally, some critics have noted that financial support for medical education cannot be efficiently targeted as long as it remains embedded in payments for patient care.

Those who favor continuing Medicare's support for medical education fear that if Medicare were to limit or completely withdraw such support, both the training of health professionals and the provision of patient care in hospitals would suffer. These problems could be intensified if other third-party payers were to follow Medicare's lead in eliminating support for medical education. Another problem is whether other Federal, State, local, or private sources of support for medical education could be found to replace Medicare's payments if they were withdrawn. Also, if Medicare were to eliminate payments for medical education, some argue that additional Medicare dollars might be required to pay for physicians' services needed to replace the care currently provided by interns and residents.

What Are the Incentive Effects of Current Policies, and Should
Current Policies be Changed to Produce Different Effects?

Supply and Distribution Issues

As discussed above, title VII of the Public Health Act has authorized funding for primary care programs in order to provide additional training opportunities in such fields as family medicine, internal medicine, and pediatrics. Observers have noted that a hospital's main consideration in deciding what types and number of residency training programs to conduct is the hospital's patient care service requirements. Observers have also noted that, compared with other specialty training programs, primary care programs receive less revenue from patient care services and research grants and thus have greater difficulty in

financing their costs. By providing support for title VII primary care training programs, Congress has sought to increase the supply of primary care physicians relative to other medical and surgical specialties. In so doing, it has also sought to address the problem of the geographic maldistribution of physicians in the country. Studies have indicated that primary care physicians, especially family practitioners, are more likely to establish their practices in medically underserved areas than other specialists.

The nature of Federal assistance provided under title VII can be described as limited in amount and focused directly on specific training goals. By contrast, Medicare's direct support for health professions education is open-ended, cost-based, and furnished without explicit regard for its overall effect on national health professions objectives regarding the supply, specialty, or geographical distribution of health professionals. Medicare simply pays its share of the costs incurred for whatever the teaching hospital decides to do. Given the concerns and observations noted above, questions have been raised as to whether Medicare and Medicaid support for graduate medical education has the effect of encouraging subspecialty training over training in primary care and is in conflict with the goals of the title VII programs. Questions have also been raised whether an upper limit should be placed on the total amount that Medicare will spend for the costs of medical education. Additional questions have been raised whether Medicare payments should be structured so as to provide incentives for hospitals and residents to choose programs more in keeping with national health professions goals regarding the aggregate supply and the distribution of health professionals.

Some people have suggested, for example, that Medicare support for residency programs be limited, either to the first 3 years of training or to the period of training necessary to become board certified (typically 3 to 5

years), as a way of both encouraging primary care training and reducing Medicare's level of support. Others have suggested weighting the amount of support favorably towards primary care residencies or supporting only primary care residencies.

The issue of foreign medical graduates has also been raised, as it pertains to the total number, cost, and distribution of residencies. Should limits be placed on Federal funding for the graduate medical education of FMGs? Should there be a differentiation between U.S. citizens who attend medical schools in other countries and citizens of other countries who seek to obtain their graduate training in this country? With respect to non-U.S. citizens, should there be a distinction between those who intend to return to their home country after completing their residency program and those who plan to stay in this country? What affect will policies based on such distinctions have on patient care, on the supply and distribution of physicians, and on teaching hospitals?

In discussing all of these issues regarding the number and distribution of residency programs, observers have noted that there is currently no governing mechanism to make sure that the myriad of decisions by individual hospitals and medical students will, in the aggregate, be consistent with national health professions goals and objectives. If it is agreed that Medicare and Medicaid policies should be revised to promote such goals and objectives, how can this be done? How and by whom will such policies be implemented?

Locus of Medical Education Training

Most of the graduate medical education in this country is being conducted in the inpatient hospital setting. However, a trend presently exists to provide patient care in a less costly ambulatory care setting. If this

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trend continues, more medical education than at present may need to be conducted in an ambulatory care setting. More frequent use of the ambulatory care setting may promote both the health professions goal of training more primary care physicians and the health policy goal of encouraging ambulatory care over inpatient care. Under these circumstances, some suggest that a certain amount of payments for medical education should be made to health maintenance organizations and other ambulatory care settings instead of to hospitals.

The Indirect Teaching Adjustment

Under the Medicare PPS system, payments for the indirect costs of medical education activities are based on an adjustment factor which is twice as large as the previously estimated amount required to cover the implicit costs of medical education. As a result, some observers argue that residents and residency programs now generate more income for the hospital than they cost. In addition, the extra payment for the indirect costs of medical education is the same for each additional resident regardless of which specialty or year of residency is involved. Since the resource demands made by residents vary with the area of clinical specialization (e.g., surgery, pediatrics, pathology, etc.) and the experience of the resident (year of training), some residency programs are believed to be much more profitable than others. Thus, some observers argue that current Medicare policy creates incentives for hospitals to provide more medical education (i.e., train more physicians) and to train a different mix of physician specialties than would be consistent with societal needs (e.g., too many general surgeons and not enough internists).

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As discussed above, the indirect teaching adjustment is also intended to serve as a proxy for several other factors which are typically associated with teaching hospitals but may also be found in non-teaching hospitals. These include case mix, severity of illness, uncompensated care, and clinical research. Should the Medicare program make additional payments for the higher costs of teaching hospitals, even if those costs are not necessarily related to teaching activities? If so, is the indirect teaching adjustment formula, which uses a measure of direct teaching activity (interns and residents per bed) as a proxy for indirect costs, a suitable way of paying for these costs in teaching hospitals? A goal of the Prospective Payment System is to encourage efficient hospital behavior by paying a fixed price for hospital services according to patient diagnosis. Is the Medicare program paying for inefficiencies in teaching hospitals through the indirect teaching adjustment? How can the Medicare program determine if its payments to teaching hospitals are adequate or too generous? As discussed above, there are currently few studies available which provide answers to these questions.

Several policy issues and alternatives are raised by this discussion. Can the costs attributable to medical education be separated from costs pertaining to other issues stemming from PPS? If reductions seem warranted in the indirect adjustment factor, should they be made across-the-board by reducing the factor for all hospitals, or should they be targeted on certain types of institutions or programs of a certain size? Should the adjustment formula be varied by type of residency or by the year of residency, as means of promoting national health professions goals?

The Administration's Proposed Changes to Medicare's Payments
for Medical Education

The President's FY 1986 Budget proposal included several changes to Medicare's Prospective Payment System for hospitals. ^{6/} Two of the proposals affect Medicare payments to hospitals for the costs of medical education. One proposal would use regulatory authority to freeze Medicare payments to hospitals for direct medical education costs at the level received by each hospital in the hospital's cost reporting year which ended in 1984. The proposal would be effective for hospital cost reporting years beginning July 1, 1985, which is the month in which most teaching hospitals begin their cost reporting periods. The Administration indicates that the freeze is in keeping with the freezes placed on other programs in the Federal budget and will be the first step towards imposing limits on direct medical education costs. Opponents of the freeze on payments for direct medical education costs argue that there appears to be no programmatic justification for this proposal except to reduce the budget deficit.

The impact of this proposal on individual teaching hospitals depends on a hospital's ability to adjust to the frozen payment level. Some hospitals might be able to maintain their current level of support for medical education by obtaining additional money from other sources through cost-saving activities within the hospital or by shifting costs to other non-Medicare payers for hospital care. Other hospitals might have to reduce the size of their medical education programs, which has implications for the pool of trained personnel in this country. Some argue that reductions which teaching hospitals might make in medical education programs could have a differential

^{6/} The President's FY 1986 budget also proposes to end all new funding for title VII and title VIII programs.

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impact on various health occupations, since reductions might be more likely to occur in training programs for nurses and allied health personnel than in programs for physicians, and more likely in residency programs for family medicine than in surgery. Another argument against the freeze proposal is that reductions which teaching hospitals might make in their residency programs could have little impact on Medicare program savings. If hospitals replace the patient care currently provided by residents with the services of physicians who are not in training, the charges for such physician services to Part B of Medicare could result in few net savings or even increased costs to the Medicare program.

A second Administration Budget proposal affecting Medicare's payments to hospitals for medical education is to seek legislative authority to reduce the indirect medical education adjustment by 50 percent. The Administration argues that there was no empirical justification for the Congress to double the factor used to calculate the indirect payment (from 5.795 percent to 11.59 percent). The Department also argues that the indirect adjustment increases the DRG payments to all teaching hospitals, whether they need the adjustment or not. Others have argued that the adjustment has resulted in windfall gains to certain teaching hospitals and provides incentives for these hospitals to increase the size of their residency programs in order to maximize payments from Medicare.

Opponents of the Administration's proposal to reduce the indirect medical education factor argue that the financial viability of teaching hospitals will be affected if they are not allowed an adjustment to the DRG payment rates sufficient to account for their higher costs. They point out that although it is called the indirect teaching adjustment, it was also intended to account

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for several concerns about inadequacies in the DRG and PPS methodologies. In their view, the factor should be left as is until a method is developed to address problems such as severity of illness, case mix, clinical research, technology innovation, and uncompensated care.

The effect that reducing the doubling of the indirect adjustment would have on teaching hospitals will vary according to how dependent the hospital has been on these additional payments to subsidize its revenues. Hospitals considered to be receiving windfall payments will have their Medicare revenues reduced but might not be greatly affected by the reduction. Other teaching hospitals dependent on this adjustment to subsidize their higher cost might be severely affected. Teaching hospitals might respond in a variety of ways to a reduction in the payment for indirect costs, including instituting measures to lower costs, reducing services which are not profitable, and reducing their teaching programs.

Opponents of both proposals argue that the Administration should be more aware of the potentially adverse effects of PPS generally and the changing competitive environment, including the growth of health maintenance organizations and preferred provider organizations, and changes in payments by third-party payers.

Issues Related to Physician Reimbursement

The physician reimbursement methods adopted by various third-party payers and the costs for physician services are intertwined with issues related to health professions education in hospitals. The patient care services that residents provide in the course of their graduate medical education to some degree substitute for the services of physicians and the hospital staff. How much does a hospital save by having relatively low-cost residents providing

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these services? Do the residents thus help pay for their graduate medical education? Would it be more costly to the hospital (and ultimately to the third-party payer) if someone other than a resident were performing the services? For example, if hospitals were to reduce the size of their teaching programs in response to reductions in payment under Medicare's Prospective Payment System, would costs increase under Part B of the Medicare program (the Supplemental Medical Insurance program) as physicians began billing for the services formerly provided by residents?

Another issue concerning payment for graduate medical education in hospitals is whether the whole variety of payments for physician services to hospital inpatients needs to be examined, including payments for physicians employed by the hospital, for attending physicians who bill separately for their services, for the teaching services provided by physicians, and for the services of residents in training. To what extent are third-party payers paying hospitals more than once for the same patient care service?

Another question is the extent to which the patient care fees collected by the clinical faculty of a medical school which flow into what are known as medical practice plans are used to subsidize medical education in the medical school and in the teaching hospital. What effect might reductions in payments to physicians have on this source of revenue for medical education?

Observers have also noted that other Medicare physician payment policies have encouraged training in non-primary care specialties. For most areas in the country, considerable variation exists in fees recognized by the program for certain medical services performed by physicians in general practice versus fees for similar services performed by specialists. For example, the prevailing charge for a routine follow-up office visit may be \$25 for a general practitioner and \$30 for a specialist. Concern has been expressed that these fee differentials may not be warranted and may have encouraged increased specialization.

Mr. WAXMAN. We also have an extensive list of distinguished and knowledgeable witnesses, and we are looking forward to hearing their insights into this complex and interesting topic. I understand that some groups that were unable to testify today have indicated an interest in submitting statements for the record. We will hold the record open for that purpose.

Let me, before we recognize our first witnesses, call upon members of the subcommittee who may wish to make opening comments.

Mr. Bilirakis, do you have any comments?

Mr. BILIRAKIS. Thank you, Mr. Chairman.

First I would like the pleasure of introducing to the members of the subcommittee and to the audience the Dean of the University of Florida Medical School, one of my alma maters, I proudly say, Dean William Deal, who is one of our witnesses here today.

I am pleased, sir, that you have called this hearing. It is certainly a very important one. I am certain that all of us on the subcommittee want to preserve the integrity of the Medicare System while at the same time ensuring that the quality of medical graduate education doesn't suffer.

It goes without saying, however, as we all know, we must not lose sight of the deficit facing this Nation, which adversely affects every American in every walk of life.

As we intend in every hearing that we hold, sir, and probably more importantly today than in most of the others, we must be objective and open-minded regardless of any personal thoughts we may have on the subject.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much.

Mr. Sikorski.

Mr. SIKORSKI. Mr. Chairman, I want to commend you for holding this hearing.

One of the things that people at home and around the country have been telling me is that these proposals here and others in the budget will have dramatic effects on the ability of young people from middle class and below families to become professionals and medical health professionals. That is bothersome.

Second, as we focus on the deficit, we must be aware of two things. I have observed both One, in the State senate, on the receiving end of Federal cuts that were made in 1981, and in the process here, that the alleged cost savings in this administration's proposals never take into consideration the bubble effect elsewhere in the budget.

You move people off VA budgets and put them onto Medicare. The savings are great to VA, but the costs to Medicare aren't accurately reflected. The savings that OMB usually associates with these cuts are never as great as promised.

With that kind of admonition, I want to commend you and welcome the excellent list of experts that we have here.

Mr. WAXMAN. Thank you very much.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

I want to follow up on my colleague from Minnesota's remarks.

I think you said it very well, Mr. Chairman, on the importance of medical education. It seems to me that one thing we want to accomplish in this hearing is to try to educate the administration on the importance of medical education. I think that the cuts they have proposed are very unwise and may well cost this Nation more in a very short time.

Second, I think the cuts that they have proposed may well raise the cost of indigent care. We still have great difficulties in this country covering indigent care and I think the cuts that the administration has proposed are unwise and may cost this nation more in the end.

So I congratulate you, Mr. Chairman, and look forward to the hearing.

Mr. WAXMAN. Thank you very much, Mr. Wyden.

The written opening remarks of Congressman Fred Eckert will be included in the record as if read.

[The opening remarks of Hon. Fred Eckert follow:]

OPENING STATEMENT OF FRED J. ECKERT

I commend the chairman for calling this hearing and looking into one area of importance to many Americans, the Federal funding for health professions education. This morning's hearing centering on the administration's latest budget proposal regarding Medicare and Medicaid's affect on this program.

In 1965, the total U.S. health care expenditures were approximately \$39 billion, representing close to six percent of the gross national product (GNP). By 1983 this had increased to roughly \$321 billion, or 10.5 percent of GNP with Department of Health and Human Services estimating the total health care expenditures to exceed \$750 billion by 1990, accounting for at least 12 to 13 percent of GNP. The size of HHS outlays in FY 1983 totalled \$276.8 billion, the world's third largest budget exceeded only by the entire budgets of the United States and Soviet Union. Between 1975 and 1985 the HHS budget tripled. However, the Reagan administration has begun to bring this money machine under control with the rate of increase declining from 17.7 percent in 1981 to 7.4 percent in 1985.

The Reagan administration has broken with the failed ideas of the 1970s when the Federal Government attempted to contain health costs by imposing controls on prices, hospital capital expenditures and the utilization of health care services. Outside of agriculture no industry is more regulated than health care. As the administration is now moving toward a more market-oriented agriculture policy I would hope the administration would continue to use market forces to encourage more efficient utilization of health care resources.

Unfortunately the public seems to expect more and more of its government's Services although I believe this expectation has been tempered in recent years, while becoming more and more reluctant to pay for them.

I look forward to these hearings and to trying to sort through the many issues surrounding health care and determining what role the Federal Government has in delivering this service.

Mr. WAXMAN. We are pleased to welcome for our first panel Dr. Henry Desmarais, the Director of Bureau of Eligibility, Reimbursement Coverage, Health Care Financing Administration; and Dr. Robert Graham, Administrator, Health Resources and Services Administration.

We are pleased to have you both with us. Your prepared statements will be made part of the record in full, and we would like to ask you to summarize those statements in around 5 minutes if you could.

STATEMENTS OF HENRY R. DESMARAIS, M.D., DIRECTOR, BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE, HEALTH CARE FINANCING ADMINISTRATION; AND ROBERT GRAHAM, M.D., ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. DESMARAIS. Thank you, Mr. Chairman, members of the subcommittee.

My name is Henry Desmarais. I am here to provide an overview of how Medicare and Medicaid currently pay hospitals for medical education costs and to describe the changes proposed in this area as part of the President's fiscal year 1986 budget.

For background, in fiscal year 1983, more than 1,300 hospitals engaged in training programs for interns and residents, for nurses and for various paramedical specialties. Three-quarters of the financing for these programs comes from patient care revenues received from Medicare, Medicaid, and other third party payers.

Medicare's policy in regard to payment for medical education goes back to the beginning of the program, although that approach certainly was seen by the Congress as a temporary one, as is reflected by statements that were included in the committee reports at that time.

Medicare pays for medical education in two ways. The first is termed direct medical education payments. This is what the chairman referred to as the open-ended cost pass through basis, and it relates to reimbursement for things like the stipends of trainees, for example, salaries of interns and residents, the compensation of the teachers of the trainees, as well as classroom and associated overhead expenditures.

The approach here, which is a cost-based payment, was unchanged by the enactment of hospital prospective payment. Assuming no changes in current policy, our actuaries tell us in fiscal year 1986, Medicare would spend approximately \$1.3 billion for direct medical education costs.

The second way Medicare pays for medical education is termed indirect medical education payments. This harkens back to a statistical observation that the costs per case are historically higher in a teaching hospital than they are in the average nonteaching hospital.

The yardstick used for making these comparisons is known as the intern and resident-to-bed ratio. Basically what we are saying is you total up how many interns and residents there are in the numerator, and the number of beds available in the hospital in the denominator, and the observation is that the higher the ratio—that is, the more interns and residents there are for every bed in the hospital—the higher the costs for the average case when you control for other factors.

Unfortunately, the cause and effect for all of this is very unclear. Some believe it is because physicians-in-training order more tests. Some believe it is because the educational setting is by its very nature inefficient, that additional services are needed in that setting; and also, many believe that it is because teaching hospitals may care for sicker patients and the severity of the illness of those

patients may not be currently taken into account by the DRG case mix classification system.

At any rate, as you know, Medicare used to control hospital payments primarily through cost limits, and beginning in 1980, those limits were adjusted upward for teaching hospitals using a very sophisticated statistical model. When Congress enacted the hospital prospective payment system, Congress decided that the formula that had originally been used to adjust for teaching purposes needed to be doubled.

So, the end result of all of this is that instead of a 5 to 6 percent increase in payments for every one-tenth increase in the ratio of interns and residents to beds, the end result was an 11.59 percent increase in the Federal portion of the prospective payment rate for teaching hospitals for every one-tenth increase in the ratio.

In short, more payment was flowing to teaching hospitals and less to nonteaching hospitals, especially in the budget neutral climate that we had during the first 2 years of the hospital prospective payment system.

Again assuming no changes in current policy, our actuaries estimate that Medicare's spending in fiscal year 1986 for these payments would be \$1.4 billion, rising to \$2.2 billion in fiscal year 1987.

Let's shift for a moment and talk about Medicaid. State Medicaid programs pay for medical education in a variety of ways. There are no very specific Federal requirements for the methods they must use.

Based on a recent survey, we know that 20 States use Medicare principles of reasonable cost reimbursement; 17 States use a hospital-specific, all-inclusive prospective per diem or per discharge rate. Medical education costs are simply included in the base from which these rates are set.

Ten States have a prospective payment rate, and they group the hospitals, and teaching programs are one criterion for grouping of the hospitals. Three States, all of which are represented in the subcommittee, have a DRG-type system, and medical education is handled separately and generally in a very similar fashion to Medicare hospital prospective payment.

While our data is not very good in that we don't specifically collect the amount of money Medicaid programs pay, our rough estimate is that this amounts to about \$400 million, of which the Federal share would be \$250 million.

While I have been speaking about our cost estimates given current law, as you know, the President has proposed two significant changes in the way Medicare pays for medical education. The first would limit Medicare payments for direct medical education programs. We plan to accomplish this through rulemaking with an effective date of July 1, 1985, with projected savings of \$150 million in fiscal year 1986, and a total of \$2.7 billion through fiscal year 1990.

The second proposal in the budget would eliminate the doubling that occurs in the indirect medical education adjustment factor. For this we are seeking a statutory change, and our estimated savings would be \$695 million in 1986, and a total of \$6.6 billion through fiscal year 1990.

The genesis of these proposals is the growing surplus in the number of physicians, the coming insolvency of the Medicare Hospital Insurance Trust Fund, and the general budgetary pressures that we all face. Nevertheless, we believe that these proposals maintain the maximum flexibility for hospitals and the medical community to design the medical education programs in ways that they believe are appropriate to serve their patients and their communities.

What I had said for direct medical education is equally applicable for our proposal for indirect medical education. The same budgetary pressures exist there. In addition, the doubling of the indirect adjustment factor was certainly arbitrary and not empirically based.

Therefore, despite the budget recommendations, Medicare will continue to contribute to the financing of graduate medical education. However, we believe that contribution will be at a more appropriate level and in a manner which fosters the efficiency demanded by our limited health care resources.

This concludes my prepared remarks.

[Testimony resumes on p. 224.]

[The prepared statement of Dr. Desmarais follows:]

STATEMENT OF

HENRY DESMARAIS, M.D.

DIRECTOR, BUREAU OF ELIGIBILITY, REIMBURSEMENT
AND COVERAGE

HEALTH CARE FINANCING ADMINISTRATION

MR. CHAIRMAN, I AM HENRY DESMARAIS, M.D., DIRECTOR OF THE HEALTH CARE FINANCING ADMINISTRATION'S (HCFA) BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE. I AM PLEASED TO BE HERE TODAY TO PROVIDE AN OVERVIEW OF HOW MEDICARE AND MEDICAID CURRENTLY REIMBURSE HOSPITALS FOR MEDICAL EDUCATION COSTS AND TO DESCRIBE THE CHANGES WE HAVE PROPOSED IN THIS AREA FOR MEDICARE IN THE FY 1986 BUDGET.

OUR BUDGET PROPOSALS ARE MOTIVATED BY THE SERIOUS DEFICIT PROBLEM FACING OUR COUNTRY TODAY, THE FUNDING CRISIS THAT THE MEDICARE HOSPITAL INSURANCE TRUST FUND WILL BE FACING IN THE 1990'S AND THE PROJECTED SURPLUS IN THE SUPPLY OF PHYSICIANS.

BACKGROUND

IN FY 1985, MORE THAN 1,300 HOSPITALS WERE ENGAGED IN EDUCATIONAL ACTIVITIES OPERATED DIRECTLY BY THE HOSPITALS INCLUDING TRAINING PROGRAMS FOR INTERNS AND RESIDENTS, NURSES AND VARIOUS PARAMEDICAL SPECIALTIES. ABOUT THREE-QUARTERS OF THE FINANCING FOR THESE PROGRAMS COMES FROM PATIENT CARE REVENUES RECEIVED FROM MEDICARE, MEDICAID AND OTHER THIRD PARTY PAYORS. ASSUMING THAT PAYMENTS FOR MEDICAL EDUCATION COSTS ARE ROUGHLY IN PROPORTION TO REIMBURSEMENTS FOR MEDICAL SERVICES, MEDICARE CONTRIBUTES THE LARGEST AMOUNT TOWARD MEDICAL EDUCATION COSTS OF ALL PAYORS,

APPROXIMATELY ONE-THIRD. MEDICAID CONTRIBUTES APPROXIMATELY ONE-TENTH. THUS MEDICARE AND MEDICAID HAVE A MAJOR IMPACT ON MEDICAL EDUCATION AND THROUGH THEIR OPEN-ENDED, COST-BASED SYSTEM OF REIMBURSEMENT FOR THESE ACTIVITIES, MAY HAVE CONTRIBUTED INADVERTANTLY TO THE CURRENT SURPLUS IN THE SUPPLY OF PHYSICIANS.

MEDICARE'S POLICY IN REGARD TO PAYMENT FOR MEDICAL EDUCATION GOES BACK TO THE BEGINNING OF THE PROGRAM. THE COMMITTEE REPORTS THAT ACCOMPANIED THE PASSAGE OF MEDICARE IN 1965 VIEWED SUPPORT FOR MEDICAL EDUCATION AS A COMMUNITY EXPENSE THAT WOULD BE SUPPORTED BY THE FEDERAL GOVERNMENT ONLY TEMPORARILY. IT STATED THAT, "UNTIL THE COMMUNITY UNDERTAKES TO BEAR SUCH EDUCATION COSTS IN SOME OTHER WAY, THAT A PART OF THE NET COST OF SUCH ACTIVITIES . . . SHOULD BE CONSIDERED AS AN ELEMENT IN THE COST OF PATIENT CARE, TO BE BORNE TO AN APPROPRIATE EXTENT BY THE HOSPITAL INSURANCE PROGRAM."

THE TERM "MEDICAL EDUCATION COSTS" ENCOMPASSES NOT ONLY THOSE COSTS ASSOCIATED WITH PROGRAMS TRAINING PHYSICIANS BUT ALSO A RANGE OF HEALTH PROFESSIONAL AND PARAPROFESSIONAL TRAINING PROGRAMS. MEDICARE REGULATIONS SPECIFICALLY RECOGNIZE 13 APPROVED PROGRAMS IN ADDITION TO GRADUATE MEDICAL EDUCATION PROGRAMS, RANGING FROM NURSING AND CYTOTECHNOLOGY TO MEDICAL RECORDS TRAINING.

MEDICARE REIMBURSEMENT FOR MEDICAL EDUCATION COSTS IS COMPOSED OF TWO SEPARATE PIECES, DIRECT COSTS AND INDIRECT COSTS, WHICH ARE REIMBURSED IN DIFFERENT WAYS.

MEDICARE DIRECT MEDICAL EDUCATION PAYMENTS

DIRECT MEDICAL EDUCATION COSTS ARE THE MORE TANGIBLE COSTS SUCH AS STIPENDS OF TRAINEES, COMPENSATION OF TEACHERS, AND CLASSROOM AND ASSOCIATED OVERHEAD. THESE DIRECT COSTS ARE NORMALLY ALLOCATED TO SPECIAL COST CENTERS UNDER MEDICARE'S COST REPORTING SYSTEM. MEDICARE'S SHARE OF THESE COSTS IS DETERMINED USING THE SAME PROCEDURES THAT WERE DEVELOPED FOR COST-BASED REIMBURSEMENT OF OTHER PATIENT CARE COSTS.

WHEN DEVELOPING A PROSPECTIVE PAYMENT SYSTEM (PPS) FOR HOSPITALS, CONGRESS APPROVED CONTINUATION OF PAYMENT FOR DIRECT MEDICAL EDUCATION COSTS, INCLUDING GRADUATE MEDICAL EDUCATION AND OTHER HEALTH PROFESSIONS' TRAINING, ON A COST-RELATED BASIS, SEPARATE FROM THE DIAGNOSIS-RELATED GROUP (DRG) PAYMENT PER CASE. ALLOWANCE OF THIS PASS-THROUGH RECOGNIZES THAT THE OPERATION OF THESE PROGRAMS AND THE ACCOMPANYING COSTS ARE CONCENTRATED IN A LIMITED NUMBER OF HOSPITALS (1300). IN FY 1986, ASSUMING NO CHANGE IN POLICY, WE ESTIMATE THAT MEDICARE EXPENDITURES FOR DIRECT MEDICAL EDUCATION WILL BE APPROXIMATELY \$1.3 BILLION.

MEDICARE INDIRECT MEDICAL EDUCATION PAYMENTS

THE PRESENCE OF MEDICAL EDUCATION PROGRAMS AND THEIR TRAINEES ALSO GENERATES ADDITIONAL COSTS FOR SUPPORT SERVICES AND OTHER ACTIVITIES THAT CANNOT BE SEPARATED EASILY FROM PATIENT CARE COSTS. THESE INDIRECT COSTS MAY INCLUDE INCREASED DEPARTMENTAL OVERHEAD AND THE HIGHER COST OF TREATING PATIENTS DUE TO A LARGER RELATIVE VOLUME OF LABORATORY TESTS AND SIMILAR SERVICES. SOME PEOPLE BELIEVE THAT THIS LARGER VOLUME OF TESTS AND SERVICES MAY BE DUE, IN PART, TO A GREATER COMPLEXITY OF CASES IN TEACHING HOSPITALS NOT CAPTURED BY OUR CASE-MIX MEASURE.

PRIOR TO PPS, UNDER COST-BASED REIMBURSEMENT, SUCH COSTS WERE GENERALLY ATTRIBUTED TO THE DEPARTMENT IN WHICH THEY WERE PROVIDED. THERE WAS NO REASON TO DETERMINE THE MAGNITUDE OF THESE INDIRECT COSTS SINCE THERE WERE VIRTUALLY NO LIMITS ON THE AMOUNT OF THE COSTS THAT WOULD BE REIMBURSED. HOWEVER, THE PRESENCE OF INDIRECT COSTS BECAME AN ISSUE WHEN LIMITS WERE PLACED ON ROUTINE OPERATING COSTS AND LATER ON COSTS PER CASE. SINCE THE LIMITS WERE DERIVED FROM GROUPING HOSPITALS, MANY OF WHICH DID NOT HAVE TEACHING PROGRAMS, THOSE HOSPITALS WITH INDIRECT MEDICAL EDUCATION COSTS WERE AT A DISADVANTAGE.

IN 1980, IN ORDER TO ADDRESS THIS PROBLEM, A FORMULA

WAS DEVELOPED TO DETERMINE AN ADJUSTMENT TO THE REIMBURSEMENT LIMITS FOR TEACHING HOSPITALS, FOR THEIR INDIRECT MEDICAL EDUCATION COSTS. THE FORMULA IS DESIGNED TO PROVIDE AN ALLOWANCE FOR THE HIGHER COSTS ASSOCIATED WITH TEACHING INSTITUTIONS AND IS DERIVED FROM AN ANALYSIS OF THE RELATIONSHIP OF COSTS PER CASE TO THE RATIO OF INTERNS AND RESIDENTS TO HOSPITAL BEDS. THIS ADJUSTMENT WAS USED TO RAISE THE LIMIT ABOVE WHICH COSTS WOULD NOT BE RECOGNIZED.

WHEN DEVELOPING THE PROSPECTIVE PAYMENT LEGISLATION, CONGRESS DETERMINED THAT AN AMOUNT, IN ADDITION TO THE OTHERWISE APPLICABLE PROSPECTIVE PAYMENT RATE, SHOULD BE PAYABLE FOR INDIRECT MEDICAL EDUCATION COSTS. RATHER THAN APPLYING THE EMPIRICALLY-BASED FACTOR USED TO ADJUST THE PAYMENT LIMITS UNDER COST-REIMBURSEMENT, CONGRESS DECIDED TO DOUBLE THAT FACTOR.

AS A RESULT, FOR COST REPORTING YEARS BEGINNING IN FISCAL YEARS 1984 AND 1985, THE INDIRECT MEDICAL EDUCATION ADJUSTMENT PROVIDES AN 11.59 PERCENT INCREASE IN THE FEDERAL PORTION OF THE PROSPECTIVE PAYMENT RATE FOR EVERY ONE-TENTH OF THE HOSPITAL'S RATIO OF INTERNS AND RESIDENTS TO BEDS.

WHEREAS, UNDER COST REIMBURSEMENT INDIRECT MEDICAL EDUCATION COSTS WERE TREATED AS AN ADJUSTMENT TO THE TEACHING HOSPITAL'S COST LIMIT AND THUS REPRESENT AN

UPPER LEVEL ON PAYMENTS, UNDER PROSPECTIVE PAYMENT THERE IS AN ACTUAL ADDITIONAL PAYMENT WHICH IS DETERMINED RETROACTIVELY BASED ON THE HOSPITAL'S TOTAL REVENUE FROM THE FEDERAL PORTION OF THE PROSPECTIVE PAYMENT RATE.

IN FY 1986, ASSUMING NO CHANGE IN POLICY, WE ESTIMATE THAT MEDICARE EXPENDITURES FOR INDIRECT MEDICAL EDUCATION WILL EQUAL APPROXIMATELY \$1.4 BILLION. IN FY 1987, WHEN THE PPS RATE IS BASED ENTIRELY ON THE FEDERAL RATE, PAYMENTS FOR INDIRECT MEDICAL EDUCATION WILL BE ABOUT \$2.2 BILLION.

WE HAVE ESTIMATED THAT IF ALL HOSPITALS UNDER PPS HAD BEEN REIMBURSED SOLELY ON THE BASIS OF THE FEDERAL REGIONAL RATE IN FISCAL YEAR 1984, THE APPROXIMATELY 118 "HEAVY" TEACHING HOSPITALS (THOSE HAVING A RATIO OF ONE OR MORE INTERN OR RESIDENT FOR EVERY FOUR BEDS) WOULD HAVE RECEIVED AN AVERAGE \$556 PER CASE FOR DIRECT MEDICAL EDUCATION IN ADDITION TO THEIR DRG PAYMENT OF \$4,079 PER CASE. FOR INDIRECT MEDICAL EDUCATION, THEY WOULD HAVE RECEIVED A 53 PERCENT ADD-ON OF \$2,158 PER CASE. IT SHOULD BE NOTED THAT THE FULL ADD-ON WILL NOT BE PAID TO HOSPITALS UNTIL FY 87 WHEN THE PPS IS FULLY PHASED-IN.

ON AVERAGE, THESE DIRECT AND INDIRECT TEACHING ADD-ONS AND DRG PAYMENT PER CASE FOR THE "HEAVY" TEACHING HOSPITALS AMOUNT TO 195 PERCENT OF THE ACTUAL DRG PAYMENT FOR NON-TEACHING HOSPITALS. THE OTHER 654 TEACHING HOSPITALS, THOSE WITH LESS THAN ONE INTERN OR RESIDENT FOR EVERY FOUR BEDS, WOULD RECEIVE AN AVERAGE DRG PAYMENT PER CASE OF \$3,659 PLUS AN ESTIMATED 5 PERCENT FOR DIRECT AND 10 PERCENT FOR INDIRECT MEDICAL EDUCATION.

PAYMENT FOR MEDICAL EDUCATION UNDER MEDICAID

THE MEDICAID PROGRAM ALSO PAYS FOR THE COST OF MEDICAL EDUCATION ACTIVITIES.

O 20 STATES PAY FOR MEDICAL EDUCATION COSTS USING THE MEDICARE PRINCIPLES OF REASONABLE COST REIMBURSEMENT. 16 OF THESE STATES USE THE MEDICARE METHODOLOGY IN ITS ENTIRETY, AND THE OTHER 4 PASS THROUGH MEDICAL EDUCATION AS PART OF AN OTHERWISE PROSPECTIVE SYSTEM.

O 17 STATES USE A HOSPITAL SPECIFIC ALL INCLUSIVE PROSPECTIVE PER DIEM OR PER DISCHARGE RATE. MEDICAL EDUCATION COSTS ARE INCLUDED IN THE BASE PERIOD COSTS WHICH ARE THEN INFLATED TO THE RATE YEAR.

O 10 STATES HAVE ADOPTED PROSPECTIVE PAYMENT SYSTEMS IN WHICH INDIVIDUAL HOSPITAL'S RATES ARE SUBJECT TO GROUP CEILINGS. IN EACH OF THESE STATES, TEACHING IS A CRITERION IN THE STATE'S GROUPING METHODOLOGY, OR THE TEACHING HOSPITALS ARE EXEMPT IN WHOLE OR IN PART FROM THE CLASS LIMITS. HOWEVER, ALL MEDICAL EDUCATION COSTS ARE GENERALLY INCLUDED IN THE DEVELOPMENT OF THE PROSPECTIVE RATE (I.E., NOT A PASS THROUGH).

O 3 STATES HAVE A DRG TYPE SYSTEM UNDER WHICH PAYMENTS FOR DIRECT AND INDIRECT MEDICAL EDUCATION COSTS ARE HANDLED SEPARATELY (E.G., USING METHODS SIMILAR TO OR IDENTICAL TO MEDICARE PPS).

SINCE GRADUATE MEDICAL EDUCATION PROGRAMS ARE CONCENTRATED IN A FEW STATES, THE BULK OF MEDICAID EXPENDITURES FOR THIS PURPOSE ARE MADE BY A FEW STATES. BASED ON A 1981 SURVEY, SEVEN STATES (NEW YORK, CALIFORNIA, ILLINOIS, MICHIGAN, NEW JERSEY, OHIO, PENNSYLVANIA) ACCOUNT FOR 58 PERCENT OF EXPENDITURES FOR RESIDENT'S STIPENDS. NEW YORK AND CALIFORNIA ALONE ACCOUNT FOR 31 PERCENT OF THESE EXPENDITURES.

HCFA DOES NOT COLLECT DATA FROM THE STATES ON PAYMENTS FOR DIRECT MEDICAL EDUCATION. HOWEVER, A ROUGH

ESTIMATE OF TOTAL FY 86 MEDICAID PAYMENTS FOR THESE ACTIVITIES IS \$400 MILLION, OF WHICH THE FEDERAL SHARE WOULD BE \$250 MILLION. TO THE EXTENT THAT STATES ARE PAYING TEACHING HOSPITALS MORE THAN NON-TEACHING HOSPITALS, THEY ARE ALSO IMPLICITLY PAYING INDIRECT MEDICAL EDUCATION COSTS.

PROPOSED CHANGES TO MEDICARE REIMBURSEMENT FOR MEDICAL EDUCATION

THE PRESIDENT'S FY 1986 BUDGET PROPOSES TO MAKE CHANGES IN THE WAY MEDICARE PAYS FOR MEDICAL EDUCATION. FIRST, WE ARE PROPOSING A REGULATORY CHANGE TO LIMIT PAYMENTS FOR DIRECT MEDICAL EDUCATION. SECOND, WE ARE PROPOSING A STATUTORY CHANGE TO ELIMINATE THE DOUBLING OF THE INDIRECT MEDICAL EDUCATION FACTOR.

THE INITIAL DECISION TO HAVE MEDICARE PAY FOR MEDICAL EDUCATION COSTS WAS MADE AT A TIME WHEN THERE WAS A SHORTAGE OF PHYSICIANS AND NURSES. TODAY, A SURPLUS OF 35,000 PHYSICIANS BY 1990 IS PROJECTED BY THE PUBLIC HEALTH SERVICE.

IN LIGHT OF THIS SURPLUS AND THE FACT THAT OVER TWO-THIRDS OF THE BUDGET FUNCTIONS IN THE PRESIDENT'S FY 1986 BUDGET WILL EXPERIENCE A REAL DECLINE IN SPENDING, IT IS HARD TO JUSTIFY THE CONTINUATION OF OUR BLANK CHECK POLICY FOR DIRECT MEDICAL EDUCATION. CLEARLY A FREEZE IS A PRUDENT ACTION.

ALSO, AS I INDICATED EARLIER, MEDICARE'S SUPPORT FOR MEDICAL EDUCATION ACTIVITIES WAS MEANT TO BE A TEMPORARY MEASURE UNTIL THE COMMUNITY COULD UNDERTAKE THE EXPENSE. IT IS TIME NOW FOR STATES AND LOCALITIES TO ASSUME A GREATER RESPONSIBILITY FOR THESE COSTS.

LIMITING PAYMENTS FOR DIRECT MEDICAL EDUCATION WILL SAVE MEDICARE \$150 MILLION IN FY 1986 AND \$2.7 BILLION THROUGH FY 1990. BESIDES PRODUCING BUDGET SAVINGS AND IMPROVING THE FINANCIAL STATUS OF THE HOSPITAL INSURANCE TRUST FUND, WE BELIEVE THAT THE LIMIT WILL PROVIDE AN INCENTIVE FOR THE MEDICAL EDUCATION COMMUNITY TO EXAMINE ITS PRIORITIES AND BEGIN TO RESTRUCTURE RESIDENCIES AND PROGRAMS FOR OTHER HEALTH PROFESSIONALS TO MEET THE CHANGING ENVIRONMENT OF THE HEALTH CARE MARKET PLACE. MEDICARE'S ROLE IS TO ENCOURAGE THESE CHANGES RATHER THAN TO DICTATE THE EDUCATIONAL OPPORTUNITIES THAT FACILITIES SHOULD OFFER.

FOR INDIRECT MEDICAL EDUCATION, OUR PROPOSAL WOULD ELIMINATE THE DOUBLING OF THE FACTOR THAT HAD BEEN MANDATED IN THE SOCIAL SECURITY AMENDMENTS OF 1983. THIS PROPOSAL WILL SAVE MEDICARE \$695 MILLION IN FY 1986 AND \$6.6 BILLION THROUGH FY 1990.

MEDICARE WILL STILL BE MAKING AN ADDITIONAL PAYMENT FOR

INDIRECT MEDICAL EDUCATION COSTS IN TEACHING HOSPITALS USING THE FACTOR HCFA DEVELOPED. IT WILL STILL RECOGNIZE THE DIFFERENCE IN COSTS BETWEEN TEACHING AND NON-TEACHING HOSPITALS. IT WILL NO LONGER, HOWEVER, RECOGNIZE DOUBLE THAT DIFFERENCE. GIVEN THE BUDGET DEFICIT AND THE STATUS OF THE HOSPITAL INSURANCE TRUST FUND IT IS HARD TO JUSTIFY SPENDING \$6.6 BILLION TO DOUBLE THIS FACTOR WITHOUT AN EMPIRICAL BASIS FOR DOING SO. SUCH A POLICY WILL ONLY ENCOURAGE INEFFICIENT BEHAVIOR.

CONCLUSION

IN SUMMARY, FACED WITH THE BUDGET DEFICIT, THE FINANCIAL CRISIS OF THE HOSPITAL INSURANCE TRUST FUND AND THE SURPLUS OF PHYSICIANS, THE FEDERAL GOVERNMENT CAN NO LONGER AFFORD TO PROVIDE A BLANK CHECK FOR MEDICAL EDUCATION COSTS. IT IS UP TO THE STATES AND LOCALITIES TO BEGIN TO ASSUME GREATER RESPONSIBILITY FOR THESE ACTIVITIES.

WE BELIEVE THAT OUR PROPOSALS WILL PROVIDE AN INCENTIVE TO THE MEDICAL EDUCATION COMMUNITY, STATES AND LOCALITIES TO BEGIN IMMEDIATELY THE PROCESS OF MAKING THE CHANGES REQUIRED TO USE AVAILABLE RESOURCES AS EFFICIENTLY AS POSSIBLE IN THE CONTEXT OF TODAY'S HEALTH CARE MARKETPLACE.

THANK YOU FOR THE OPPORTUNITY TO TESTIFY. I WILL BE PLEASED TO ANSWER ANY OF YOUR QUESTIONS.

Mr. WAXMAN. Thank you very much.
Dr. Graham.

STATEMENT OF ROBERT GRAHAM, M.D.

Dr. GRAHAM. Mr. Chairman, since my statement does go into very great detail on these matters, I will just summarize the particular interests that our agency and the Public Health Service has on these issues.

As you have indicated in your opening statement, you would like to focus on the set of issues around title XVIII and title XIX programs, and Dr. Desmarais has talked about some of the Administration's posture on those issues.

What we are trying to accomplish and are working within the Department, with HCFA, to do is to assure that there is a system of graduate medical education in the United States which meets the needs of the public.

I think the committee is well aware that graduate medical education is largely the responsibility—in terms of accreditation and distribution of residencies and the assignment of priorities—of the medical profession itself, and there is a long history of that profession having established a very complicated and, I think, effective system of graduate medical education of which we have the benefit today.

Historically, the Federal Government, the State governments and other payers have worked within that system to assure there has been a steady supply of physicians.

I think it is timely that the conversations the committee has undertaken today, and other committees of the Congress have initiated in the last 2 or 3 months, be occurring because tremendous changes have taken place in the 10 years since the last major national debate about graduate medical education, the supply of physicians, and their distribution by specialty and geography.

We have a very different type of health care system today and it is changing very rapidly; so I think within the context of all of us being legitimately concerned about what the total Federal outlays are for health care expenditures and the subset of those outlays for graduate education or undergraduate education, the priorities that we are trying to address and find some way to continue to meet is to make sure that, for U.S. citizens graduating from U.S. medical schools, there continues to be a graduate education system which provides them the opportunity to pursue their education in one field or another; and that, to the best of our ability and within the appropriate guidelines, we continue to emphasize the need for an increasing number of physicians to go into primary care, which, in the face of a generally acknowledged oversupply of physicians, appears to be the one major area in the United States where we may still be lagging somewhat.

I think with that overview, sir, I would like to use the rest of the time to pursue the questions and discussions of you and the other members.

[The prepared statement of Dr. Graham follows:]

STATEMENT BY

ROBERT GRAHAM, M.D.

ADMINISTRATOR, HEALTH RESOURCES

AND SERVICES ADMINISTRATION

Mr. Chairman and Members of the Subcommittee:

I am Dr. Robert Graham, Administrator of the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services. I am pleased to have the opportunity to appear before you to discuss various questions relating to graduate medical education and the Public Health Service's role with respect to physician supply and specialty distribution.

Mr. Chairman, this is an appropriate time to discuss the question of how best to pay the costs of graduate medical education. Over the past decade, major changes have occurred in physician supply, in numbers and types of educational programs, and in ways of providing health care. New approaches to the funding of physician residency training, including funding from Federal sources, may be necessary or desirable.

In my testimony, I shall describe briefly the Health Resources and Services Administration's activities relating to graduate medical education. I should like also to make a few comments on projected physician supply as related to trends in specialty distribution.

My remarks are based on the assumption that non-Federal organizations and groups — educational institutions, health care facilities, professional associations, accrediting bodies, and State and local governments, among others — will continue to lead in developing and maintaining our complex system of advanced clinical training of physicians. The Federal Government's role will be one of encouraging or

facilitating the work of those non-Federal groups that have taken primary responsibility, up to now, for establishing a graduate medical education system that, if it needs certain improvements, is recognized throughout the world for its overall excellence in training competent physicians.

FY 1986 Budget

As you know, the President's 1986 budget requests no funds for health professions education support. In view of a steadily increasing supply of physicians and nurses, projected National surpluses in these fields by the end of this decade, improving geographic distribution of health professionals, and the need for budgetary constraints, continued Federal subsidy of health professions education programs is no longer required. All major studies of supply and demand for health professionals conclude that virtually all health professions occupations are in excess supply and that supply growth will continue to outstrip demand increases for the remainder of the decade.

Although no budget authority is requested for health professions assistance in 1986, approximately \$67 million will continue to be available for student loans from the revolving funds at approximately 1,400 health professions and nursing schools. (This does not include Department of Education or Department of Defense programs.) These repaid loan monies will enable schools to continue providing assistance to economically disadvantaged students. Significantly improved debt collection methods should help ensure an adequate funding source.

In addition, the Health Education Assistance Loan program (HEAL) will provide \$100 million of new guarantees for private loans to graduate students in health professions schools.

Current HRSA Programs

Mr. Chairman, current HRSA programs (authorized under Title VII of the PHS Act) relating most directly to graduate medical education are several support programs that partially subsidize the training of primary care physicians. Thus, the Bureau of Health Professions has provided aid to medical and osteopathic schools and other entities as appropriate for family medicine training (residents, faculty, and undergraduate), training in general internal medicine and general pediatrics (residents, faculty), and the establishment of departments of family medicine. In the fiscal year 1985, this aid will total about \$60 million. Grants have been awarded under a competitive peer review process to those applicants making the strongest case for receiving assistance. This is so-called "last dollar" aid, which means that the Federal share of costs is limited to that which cannot be raised from other funding sources.

There are strong indications that these primary care training grant programs have been successful in enhancing primary health care delivery over the last decade. In a short nine-month period between December 31, 1983, and September 30, 1984, there was a 16 percent decrease reported in the number of primary care health manpower shortage areas, along with a 24 percent decrease in the number of primary care physicians needed in these areas. Between 1973 and 1984 (according to AMA residency directories), the number of family practice programs and filled residency

positions grew from 206 to 386 and from 1765 to 7408, respectively. In the field of general pediatrics, Federal aid has enabled programs to increase the time of residents in training in an ambulatory setting; also, a substantial portion of graduates of the programs are located in small cities and towns in rural areas and in socioeconomically deprived sections of inner cities.

Another Bureau of Health Professions program that has made a major contribution to the training of primary care physicians is the area health education center, or AHEC, program. This program has helped increase the supply of health professionals in areas remote from existing training institutions by developing training programs in these areas. Emphasizing a regional approach to meeting health personnel needs in shortage areas, it has provided funds to medical and osteopathic schools for the purpose of decentralizing education by having portions of training provided in primary medical care shortage areas. Among the training programs supported have been those for primary care residency training. Many AHECs have continued to operate successfully after the start-up period of Federal support ends.

In addition to providing support for primary care physician training, the Bureau of Health Professions has pursued efforts to improve the availability and quality of information on the status of health professions personnel, including data on physician supply and distribution. Working in cooperation with other Federal agencies, States, local communities, professional organizations, and other groups,

we have assembled and analyzed data on current supply of practitioners and students and estimated future requirements for personnel. The Bureau also designates health manpower shortage areas, among them primary care physician shortage areas.

Based on the analysis of data, our most recent report to the Congress on the status of health personnel (May 1984) describes the growth of physician training programs over the past 20 years, notes the increase in the supply of practitioners, and documents progress in the development of residency training programs in the primary care specialties of internal medicine, family practice, pediatrics, and obstetrics and gynecology. The report also summarizes available data on the extent to which, in part as a consequence of the increasing supply of physicians, more practicing physicians are locating in counties that have lower physician-to-population ratios.

Increasing Physician Surpluses

Mr. Chairman, in 1980 the Graduate Medical Education National Advisory Committee, an advisory body created by the Secretary to coordinate public and private efforts in the quest for an equitable distribution of physician services, produced a series of projections for physician specialty distribution. Using an "adjusted needs-based" approach, the Committee generated physician service requirements as a function of expected national morbidity, modified by expert opinion on the fraction of this morbidity requiring medical intervention, within limits on what was achievable by 1990 under expected constraints of the health care system.

Some major findings of GMENAC were: There would be 70,000 more physicians than required in 1990. There would be a surplus in virtually all specialties. The primary care specialties of osteopathic general practice, family practice, general internal medicine, and general pediatrics would be in approximate balance. Shortages would be experienced only in psychiatry and emergency medicine. Based on their findings, GMENAC made a total of forty recommendations, as well as many "supportive recommendations," for action by the Federal and non-Federal sectors.

Key among the GMENAC recommendations for Federal action relating to physician specialty training were that capitation payments to medical schools for the purpose of increasing class size or "influencing specialty choice should be discontinued; that special purpose grants to medical schools should be continued; and that public and private reimbursement policies should be adjusted to emphasize ambulatory care services and training (among other purposes). The Committee called for further study of needs for certain specialties studied by GMENAC only on a tentative basis.

Consistent with the GMENAC recommendations, the Administration successfully sought termination of the authority for capitation grants to medical schools, effective in FY 1982. Overall, programs designed to increase the aggregate supply of physicians have been phased out, or are proposed for termination in FY 1986. Financial support for primary care physician training has been continued through 1985. Requirements for six

additional specialties and subspecialties were studied in depth using GMENAC's adjusted needs-based methodology, resulting in a slight decrease from 70,000 to 63,000 in the Committee's projected aggregate physician surplus in 1990.

Since the GMENAC report was published, the Bureau of Health Professions has continued to provide alternative estimates of requirements for physicians based on projected demand for medical services, using a model employing an "adjusted utilization" approach. All of the alternative estimates support projections of large surpluses of health professionals. The "adjusted utilization" approach assumes that recent patterns of medical services utilization and productivity will continue, with adjustments to reflect projected changes in the population and per capita utilization, among other factors. Using this approach, we estimate surpluses in overall physician supply of about 35,000 in 1990 and rising to about 51,800 in the year 2000.

Recent Bureau estimates of future physician supply provide additional information on the probable specialty distribution of physicians. For example, the number of allopathic and osteopathic physicians in the primary care specialties of internal medicine, general/family practice, and pediatrics is projected to increase by approximately 117,900 between 1981 and 2000. The ratio of these physicians to the population is projected to increase from 84 per 100,000 population in 1981 to 115 per 100,000 population in 2000--a 37 percent increase.

Mr. Chairman, over the next year or so, much additional information will become available on detailed aspects of the existing system of graduate medical education. A current Department study, "A Study of the Financing of Graduate Medical Education," is expected to provide more definitive cost data for residency training. Several key professional associations are conducting studies or have established committees to examine the issue.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you may have.

Mr. WAXMAN. Thank you very much. That is a good overview, and I appreciate the testimony of both of you.

Dr. Desmarais, forgive me for mauling your name.

Dr. DESMARAIS. It happens all the time, Mr. Chairman.

Mr. WAXMAN. Let me get started with you. Looking at the HCFA aspects of this problem, obviously what we do in reimbursement may have even more of an impact on what we are going to be able to do and what we have done in terms of the manpower programs that we have traditionally relied on in the last ten years to try to shape the whole picture on distribution among specialties and geographically.

From what I understand of your testimony about Medicaid payments for graduate medical education, if I hear you correctly, the bottom line is essentially all of the state Medicaid programs are paying for graduate Medical education one way or another, and they appear to be paying at approximately the same level Medicare would pay.

Is that a fair statement? Is that a reasonable summary?

Dr. DESMARAIS. Reasonable. There are no Federal requirements among States other than they have to pay amounts sufficient for efficient providers of care. That includes not only for medical education but for patient care in general. So there is no very specific Federal guidance on how they ought to pay for medical education costs. They do it in a variety of ways.

Mr. WAXMAN. Dr. Desmarais, what is the total amount of both direct and indirect costs for the Medicaid program?

Dr. DESMARAIS. We have only a very rough estimate of the cost. Basically for the direct costs, they would be \$400 million total, both from the Federal and the State share of that. We really don't have any good numbers for the indirect portion because that generally gets built into the payment rates that States set for all of patient care costs.

Mr. WAXMAN. How do you anticipate that the States will handle the situation if your budget proposals for Medicare are adopted?

Dr. DESMARAIS. They have a great deal of flexibility. Those who strictly follow Medicare principles would continue to do so, but they have flexibility not to follow them directly and could certainly craft their own alternative approach. Many of them already do that. Many of them are not following the Medicare principles. In fact, more than half are not.

Mr. WAXMAN. In Medicare you are proposing to freeze the direct payments for graduate medical education by regulation rather than seeking legislation. Can you explain to us why you think you can do this by regulation?

Dr. DESMARAIS. First, Mr. Chairman, the statutory base for our payment system only calls for us paying for the salaries of interns and residents. It doesn't speak to the associated costs of overhead and classroom. It does not speak to financing of nursing programs or paramedical professional programs. So we do believe we have a tremendous latitude.

In addition, the payments themselves are not free from the other statutory requirements that they be reasonable. Certainly we have set limits historically for our payments for patient care costs, and

we believe we have the same obligation and duty to do so for the medical education program.

Mr. WAXMAN. Now, in the proposal on indirect teaching expenses adjustment, you are talking about eliminating, as you put it, the doubling of the factor. Isn't it true, however, that when Congress set the factor in 1983 for purposes of the prospective payment systems, it did so expressly out of the concern of several flaws or inadequacies in the DRG methodology.

Would you agree at this time it includes more than just an adjustment for the indirect costs generated by the hospital's teaching activities and includes a proxy to correct for other factors that are typically associated with hospitals that serve sicker patients and a disproportionate share of low income patients?

Dr. DESMARAIS. Your remarks are perfectly accurate from the statistical base where we started, which gave us a 5.79 percent adjustment. The problem is we now have an 11.59 percent because that factor got doubled. So all of the other—the proxy nature of the measurement we know exists, and we don't know exactly what is involved in that.

But the doubling came after that observation.

Mr. WAXMAN. So all these factors are supposed to be part of that cost that the Government is incurring in reimbursement.

Dr. DESMARAIS. Right. The initial statistical observation said costs are higher but we don't know why. That gives us a 5 to 6 percent adjustment and not 11.59 percent adjustment, which is where we are at today.

Mr. WAXMAN. Shouldn't we be cautious about changing the adjustment factor before some progress has been made on resolving these other concerns to know exactly what the impact is going to be?

Dr. DESMARAIS. I think what we are saying is, based on our statistical observation, if we undouble it, we are accounting for all of those things in our payment, and certainly we do plan on our continuing to work on severity of illness and other types of refinements for hospital prospective payment. But we don't think we need to do those things before we undouble what really had no rationale for doubling.

There was a general concern in the Congress, but we believe from a statistical and analytical perspective the original formula is adequate.

Mr. WAXMAN. Well, let's look at some of the impact that we might expect from this change. One of the justifications for freezing payments for direct costs is a projected surplus of physicians. That strikes me as a rather superficial and makeshift argument.

Can you explain to us how freezing support for graduate medical education is going to affect the total number of doctors that we produce?

Dr. DESMARAIS. We are not exactly sure how it will. We do know there is a growing surplus, and therefore, that, we believe, justifies a reduction or a limitation on Medicare's participation. We honestly don't know exactly how individual providers will respond. Some of them may look for other sources of funding and keep their programs unchanged. Others may say the world is changing, therefore

we need to reexamine our medical education programs and maybe drop some or reduce the size of them.

So certainly medical schools are undergoing that kind of a reexamination today, and I suspect graduate medical education probably will follow as well.

Mr. WAXMAN. Do you know what the impact will be in terms of distribution by specialty or geography?

Dr. DESMARAIS. No.

Mr. WAXMAN. Has there been any consideration of what impact would come about in that area as a result of these policies?

Dr. DESMARAIS. The proposals are not designed to force us into setting some kind of quota system for individual providers as to what kind of medical education programs they can develop or anything else. Basically, it is limiting Medicare's participation and then letting the private sector make the kinds of decisions we believe they can make.

Mr. WAXMAN. It is rather a crude way of doing it to say this is the money and you let the whole thing sort out. Did you have any process where you looked to see, well, what is the impact going to be on this manpower question, distribution between specialties, distribution geographically, all these other needs that seem to be addressed in this factor that we have when we are reimbursing teaching hospitals?

Dr. DESMARAIS. Perhaps Dr. Graham would like to expand, but when you look at the growing surplus of physicians, certainly in the primary care sector there is a growing supply of those types of physicians. We know, based on a number of studies, that market forces are working and physicians are moving into areas they did not historically "inhabit," if you will, and providing care to people that may well have been underserved at an earlier point in time.

We just believe the trend is in the right direction, and therefore Medicare's limitation of its participation is appropriate.

Mr. WAXMAN. Let me ask Dr. Graham, then, if you had an opportunity or whether you were brought into the decision by HCFA for this policy recommendation change to look at what the impact may be in terms of manpower questions.

Dr. GRAHAM. We have had ongoing discussions with HCFA on a variety of levels. There was no specific meeting that I am aware of between the Public Health Service and Dr. Davis and Dr. Desmarais about the specific proposal, but on a number of different elements of the day-to-day business of the Health Care Financing Administration and the Public Health Service, we do have an opportunity to talk to the staff of HCFA.

In my experience, at least, they have been appropriately concerned about our point of view while still being concerned about their major responsibility, which is to keep the trust fund healthy and continue providing services.

In terms of the specific proposal or strategy which is laid out in terms of an across-the-board approach, I must say I do not find it to be any less rational, if you will, than the approach that we have had for 10 or 15 years, which, as Dr. Desmarais has pointed out, has been a pass-through system.

It seems to me what HCFA is doing right now is consistent with those past principles.

Mr. WAXMAN. It seems we don't quite know what we are paying for. We know we are paying for a lot of different factors in this system. Now we are going to pay for less, and we don't know how all those factors are going to be addressed.

Of course, one of the important areas is the manpower distribution question. It seems to me the assumption is we have got a surplus of physicians, period. But as you stated, Dr. Graham, that is an oversimplification of the issue. It is not just an oversupply of physicians. There is a question of where those physicians are located, both in specialty and geographical distribution.

You don't doubt that there is going to be some impact. We just don't know for sure what the impact is going to be.

Dr. GRAHAM. Oh, no. But I do believe it is a far broader question than simply the reimbursement policies of titles XVIII and XIX, as important as those policies are. What I was alluding to in my opening remarks is that we have a system that I believe is undergoing changes more rapidly than any of us can really appreciate.

When you have to read the Wall Street Journal day to day to understand what is happening in health care delivery, you know that things are quite different than they were 5 years ago.

Mr. WAXMAN. You get more in the Federal Register than in the Wall Street Journal.

Dr. GRAHAM. I have not yet passed my language competency test to read the Federal Register. As near as I can tell, that takes a J.D. degree.

But less facetiously, the changes that have taken place—the change in the reimbursement system and DRG's, the increasing number of HMO's, IPA's, PPO's, the saturation, if you will, of subspecialty practice opportunities within urban areas, which is causing a number of large training centers, absent any movement on the part of the Federal Government, to look at how many plastic surgeons we have in our programs, how many orthopedic surgeons, and on down the line—have resulted in what I was trying to refer to as the tremendous complexity of the current questions.

Certainly we have a role for our part in the Federal Government, with the HCFA authorities and with the Public Health Services authorities, to make certain proposals and to try to set certain things in motion. We do have a concern, historically within the Public Health Service, in terms of the balance of numbers of practitioners, but I think to suggest that that concern can be wholly met or is totally unmet by a specific proposal from HCFA at this point in time is probably being unfair to the authorities that they administer.

Mr. WAXMAN. Thank you.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Drs. Graham and Desmarais, it seems to me, looking at it logically—that doesn't always apply, of course—that the current system of reimbursement which is done retroactively on the basis of costs would give hospitals no incentives whatsoever to operate in their teaching programs efficiently or to even curtail their size. Would you agree with that statement?

Dr. DESMARAIS. Yes, that is certainly true. Your payment is strictly factored by how much you spend. Then you have no incen-

tive to examine how are you spending that money; how efficient you are being.

Mr. BILIRAKIS. So actually, then, is HCFA looking at any long-term strategies in order to provide reimbursement for direct costs in such a way that will give hospitals and medical schools incentives to operate more efficiently?

Dr. DESMARAIS. We believe the limitation on payment that we are proposing certainly starts our process, and we intend to continue to collect data in the Department about what is occurring in the physician supply milieu and so on. Certainly we are trying to continue to make refinements in the way we pay for health care under the Medicare and Medicaid Programs, but certainly we believe this is an important first step.

Mr. BILIRAKIS. We are talking about the Federal Government on a bottomline basis getting even more involved with teaching hospitals and the medical schools; are we not? Because if we are going to actually want to moderate in a much closer manner efficiency to tie in maybe some sort of formula to reimbursement, we are actually talking about the Government becoming more and more involved in their lives.

Dr. DESMARAIS. It is a particular type of involvement. It doesn't dictate what an individual provider must do, but simply provides certain incentives, and the kind of payment limitation certainly is a powerful incentive to look at what you are doing as opposed to saying we are not only going to limit your payment but we are going to tell you exactly what to do in your individual hospital.

That is what we are trying to avoid here in the same way we have avoided it in the hospital prospective payment system. We limit the payment amount, and we don't dictate what occurs in that individual hospital.

Mr. BILIRAKIS. The real world is—and we have got to face the fact that this is the real world. Many of my friends are medical doctors. I would say that probably every one of them are fiscal conservatives. I would say probably all the M.D.'s in this room are in that category, too.

But it comes, of course, to being fiscally conservative regarding our particular realm. All of a sudden we aren't so fiscally conservative any longer. I think that is probably what we are going to hear. We have a long list of medical doctors from various universities throughout the country. I know they are all going to testify basically the same sort of thing.

Well, now you two are medical doctors. You are doctors first before you are members of the administration. I think I can categorize you as being members of the administration, so to speak. Would you say as medical doctors you are concerned about medical care, you are concerned about proper teaching methods and all of these good things.

Are there any negative aspects to the administration's policy to freeze direct medical education payments? I mean you have already admitted that there is going to be some sort of an effect. Does that mean it will necessarily be a negative effect, or might the effect be that basically we are going to be telling the teaching hospitals to become more efficient and that sort of thing? Is it going to be a negative effect?

Dr. DESMARAIS. Certainly——

Mr. BILIRAKIS. Remember you are doctors first.

Dr. DESMARAIS. We certainly believe it is more positive than negative. Certainly any time you reduce payment for something, people are unhappy, and also, when people don't know exactly what that will lead to, they become uncomfortable. So I think unhappiness and that discomfort is something that exists.

But again, I think there is a rationale for making the proposals that we are making given the broader context of the Federal budget and the Medicare trust fund, and we certainly believe the benefits far outweigh any other concerns.

Mr. BILIRAKIS. Do you feel that the medical education facilities will clearly survive this, without any real bottomline adverse effect on their overall teaching plans and quality of work?

Dr. DESMARAIS. Yes, I believe they will. They may look for other sources of funding; there may be a variety of changes. But I don't believe the types of proposals we are talking about are so draconian or so unreasonable that prudent providers cannot respond appropriately.

Mr. BILIRAKIS. Thank you. Thank you, gentlemen. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. Desmarais, your comments concern me greatly, because I think they are just bad news for the poor in this country. We know that millions of indigents fall between the cracks. They aren't getting adequate care. And the teaching hospitals try to pick up a good portion of that.

It seems to me that your proposals are going to put the squeeze on indigent care even more. I listened very carefully to your testimony, and what I got out of it was essentially something along the lines of:

We don't know what the effects are going to be, we don't know what's going to happen, but we are going to go ahead and do it, anyway, and then go from there.

I just wish it were that easy. I wish it were possible to just make these kinds of changes and then go from there, but I think a lot of poor people in this country are going to get hurt and I think that is inevitable under your plan.

Do you think that the statistical analysis that was done for the purposes of cost limits is valid when applied to the DRG system?

Dr. DESMARAIS. The analogy has been repeated a number of different times. The numbers vary from 4.7 percent to 6.06 percent adjustment, and with doubling we are at 11.59. But we believe the analysis remains equally valid today as it did then when it was used in 1980.

Mr. WYDEN. How would you react to my evaluation of the system—or what these changes you propose are going to do to care for the indigent?

Dr. DESMARAIS. I think uncompensated care is a much broader issue. Certainly uncompensated care is not provided totally by teaching hospitals. We have been examining the whole issue of uncompensated care. We also owe the Congress a report on that subject.

We know a variety of innovative kinds of things are happening out there in various States, Florida being one of them, where States are attempting to deal with uncompensated care.

But I think it is a very different matter to say that the Medicare Program, through a medical education payment, ought to subsidize uncompensated care. I don't think that was ever intended in the Medicare statute.

Mr. WYDEN. I would certainly agree with you on your analysis that it is a broad subject and very complicated one. I don't think there is any question that the proposal that you are going to try and put in place is going to hurt. They are going to hurt poor people.

Now maybe we will come back with a broader solution later in the Congress, and I sure hope that we do, and I agree with you, it is a broad topic, but there is no doubt in my mind that the day your proposals go through, teaching hospitals are going to be able to do less for the indigent. I think that is a shame, when millions of indigents are already falling between the cracks in this country.

Dr. Graham, in your view, is it appropriate and feasible to expand the use of HMO's and other ambulatory settings as sites for residency training?

Dr. GRAHAM. I believe we are starting to see an increasing level of HMO's or closed panel practices as sites for either part or all of residency training. To the extent that those organizations and their physician staffs feel that they can meet their primary mission to the enrollees, and at the same time provide a site of training for other physicians, whether they be in primary care or subspecialties, I think that is excellent.

We are seeing a growth rate of HMO enrollment of around 20 percent a year for the last 3 years. This implies to me that there are going to be a large number of American citizens in HMO's as we go into the 1990's.

The more physicians that have some part of their training and experience in that type of practice, the better off we are going to be.

Mr. WYDEN. Dr. Graham, what factors in your view influence a teaching hospital in deciding what residencies to offer a medical student and the medical student deciding what residencies he might pursue?

Dr. GRAHAM. Gosh. Have you got all morning? The decisionmaking process for individual residencies to decide the number of positions to offer or what residencies to establish in most teaching hospitals or medical schools is a decentralized decisionmaking process.

In other words, there is not a czar in the medical school who decides we are going to have 15 internal medicine, eight family practice, three ophthalmology. But those department chairmen decide whether or not they have the resources available to carry out a training program. They certainly have to get authority or permission from the administration of their institution to apply for accreditation.

But then they go to their own residency review committee which is in the private sector, as I outlined before, and they have to show that they have the resources available to carry out training, and they propose a certain number of trainees per year or total for the

program. And the residency review committee generally says yes, these resources are adequate; or we don't have quite enough to train 10, why don't you think about six? But it is highly decentralized for that part of the question.

And one of the criticisms that can be made is that there is not a high degree of coordination. You have that tradeoff.

Mr. WYDEN. Let me if I might, because our time is brief. Do you think we can influence these decisions with financial incentives?

Dr. GRAHAM. To some extent, I think our experience of the last 20 years has been there is some ability to influence those decisions. The chairman asked the degree of conversation and work we have with HCFA, between Public Health Service and HCFA. One of the things I know we have been talking about for the last 10 years is the extent to which the present reimbursement pattern may provide incentives for the establishment of in-patient care specialties or subspecialties to the detriment of primary care. And the HCFA compatriots have been sympathetic to our concerns, particularly as we tried to sort out some things about 6 or 7 years ago about our Primary Care Programs. There is something of an incentive now in the reimbursement system for totally hospital-based training versus ambulatory-based training, because the formula for the reimbursement is different.

Using that as an example, I would say yes, there probably are incentives that can be established through a reimbursement system that will lead more to one type of training than to another.

Mr. WYDEN. Frankly, I think that is yet another reason why we should be more cautious than the administration's proposals seem to be in going forward and suddenly turning in a dramatically different direction.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Wyden.

Mr. Eckert.

Mr. ECKERT. Thank you.

Dr. Graham, back in 1980 the Graduate Medical Education National Advisory Committee reported that by 1990 there would be 70,000 more physicians than required. You indicated that would be about half of that, about 35,000. What has changed to cause that?

Dr. GRAHAM. The major difference between those two numbers is the fact that GMENAC was a one-time exercise and it used one specific type of Statistical Modeling Program to make a set of estimates based on a set of assumptions, and we came up with our 70,000 physician estimate.

Actually that was updated about 18 months later to 63,000. The 35,000 number comes from an ongoing model which the Bureau of Health Professions runs every year for purposes of a report to Congress. It uses slightly different assumptions. It is done in a somewhat different fashion.

I think the significance is that within the degree of potential error for both of those models, they are pointing to a substantial excess supply of physicians in the United States, and I believe what we have seen since 1980, when the GMENAC report was first released, a growing consensus that that is indeed the reality which faces us.

Mr. ECKERT. That GMENAC report also recommended public and private reimbursement policies be adjusted to emphasize primary care processes and training. How do you think that should be done?

Dr. GRAHAM. I would be happy to submit for the record, sir, some of the more detailed conversations that GMENAC had about that, and some of the other reviews that we have made since that time. As I alluded to earlier, that is a conversation that we have continually between our staff and Dr. Desmarais' staff and others in HCFA, looking at the manner in which Primary Care Residency Programs, internal medicine, pediatrics, family medicine, which have a high proportion of their training done outside the hospital setting, receive reimbursement, not only from HCFA but from all other payers; and the implication that those payment practices have for numbers of trainees or the viability of training programs compared to what happens if you do all of the training inside the hospital. It gets very complex, but there could be some ways that could be changed over a period of time.

Mr. ECKERT. Thank you, Mr. Chairman. I have no further questions.

Mr. WAXMAN. Thank you very much.

Mrs. Collins.

Mrs. COLLINS. Thank you, Mr. Chairman.

Mr. Chairman, I have an opening statement that I would like to include at the appropriate place in the record.

Mr. WAXMAN. Without objection, your opening statement and that of any other member who wishes to submit one will be included in the record at the appropriate place.

[Mrs. Collins' opening statement follows:]

OPENING STATEMENT OF HON. CARDISS COLLINS

Mr. Chairman, I wish to thank you for holding this hearing the purpose of which is to shed light on budget cuts in medical education. Given the large number of hospital beds (9,200) in my district of Chicago, I am sensitive to the need to provide funding for medical education.

Federal and State governments currently support several programs to assist in the education of our medical care providers, and ensure the sanctity of medicine. These programs include payments by Medicare and Medicaid to hospitals for vital training programs for nurses, medical students, interns and residents, and various paramedical specialties. The President has proposed to cut support for some of these programs in the 1986 budget. He wants to freeze some of these programs while cutting others in half. These drastic reductions would prove to be detrimental to medical education, and in turn, to our medical care.

In my district, there are four teaching hospitals which employ many of the nearly 3,500 residents and interns in Chicago. If budget reductions are implemented, these hospitals stand to lose the monies required to fund essential medical training programs. The loss of funds would substantially reduce the number of interns and residents, medical students, nurses, and paramedical professionals which could be trained by each hospital. If there are fewer programs to instruct these individuals, this could lead to severe manpower shortages in our health care industries. If there are manpower shortages, the quality of care will suffer immensely.

While reducing the Federal deficit is important, it cannot be done at the expense of services crucial to the American public. Quality medical attention is one of the services which no one can manage to live without. It is up to us, as Members of Congress, to guarantee the availability of educational programs, because quality education is vital to quality health care!

Mr. Chairman, I look forward to working with you on this issue, which not only merits our attention, but demands it!

Thank you.

Mrs. COLLINS. Thank you very much, Mr. Chairman.

There was an article in this past weekend's Chicago Sun-Times or Chicago Tribune that indicated that of the approximately 35 physicians who were going to be serving internships in one of the four training institutions that are in my district, only two had been trained in America.

I wonder how that stands in light of your decision to phase Medicare and Medicaid support payment systems for physicians and other people in the medical profession?

Dr. GRAHAM. If I could just comment first, ma'am.

Mrs. COLLINS. Please.

Dr. GRAHAM. That would be, for that particular institution, a very atypical pattern for the United States. In general we have approximately 3,000 non-U.S. trained physicians per year entering graduate medical education. That is compared to approximately 16,500 U.S.-trained physicians.

There are certain hospitals, and they are more located around the Great Lakes area and the Northeast, which have had a preponderance of foreign medical graduates in their training programs. But for most of the training programs in the United States now, particularly because there has been a gradual shrinkage of the total number of first-year graduate medical education positions, it is increasingly more difficult for non-U.S. trained physicians to achieve first-year training positions.

What that means is they don't match, they are not able year after year, to achieve graduate education in the United States. The foreign nationals are predominantly here on family-preference visas because we no longer have a special exemption for foreign nationals. The U.S. nationals are largely products of the offshore Caribbean medical schools. About 1,800 U.S. citizens foreign medical graduate per year are entering GME in the United States. At the present time it is getting more and more difficult for non-U.S. graduates to achieve graduate medical education.

I can't respond to the Medicare-Medicaid part of your question, but in terms of that specific institution, that is an atypical institution.

Mrs. COLLINS. Thank you. Now can you respond to the Medicare-Medicaid portion of it, please?

Dr. DESMARAIS. Yes, ma'am. Again the proposal would simply limit the Medicare reimbursement if there were foreign Medicare graduates who were doing the work in that particular institution.

It is irrelevant for the purposes of the limitation. We do know that there are proposals being considered on Capitol Hill that would say if you have too many foreign medical graduates, then somehow Medicare's reimbursement ought to be less in that particular instance. But that is not a position we are taking here. We are saying no matter who your interns and residents are and where they were trained, we are simply establishing a limitation on Medicare's payment, and the institution can react appropriately.

Mrs. COLLINS. If Medicare's payment were not frozen would you have more American graduate students applying for that kind of training?

Dr. DESMARAIS. Not necessarily. There are a number of positions and only so many American graduates from medical schools, so other positions, foreign-trained physicians apply for them historically.

Mrs. COLLINS. I, for one, am worried about the quality of care that I will be provided, if we begin to freeze the Medicare-Medicaid support payment systems for graduate students in medicine, I am concerned about the quality of care that we are going to be getting in our country 5 or 10 years from now. Is that a concern of yours?

Dr. DESMARAIS. Quality of care is our concern. As you know, we have a peer review organization system that monitors the quality of care in each hospital in the country, whether it is a teaching hospital or not. We will continue to do that to monitor quality.

Mrs. COLLINS. Has that peer review system prepared any kind of projection of what the medical care is likely to be if you don't have graduate medical students?

Dr. DESMARAIS. Again, our proposal doesn't say not to have graduate medical education——

Mrs. COLLINS. Because it is going to be substantially cut back, isn't it?

Dr. DESMARAIS. Well, it says that they may have to become more efficient, because the total pool of money that Medicare will provide will be limited.

Mrs. COLLINS. How would it become more efficient?

Dr. DESMARAIS. They may decrease the size of the programs, or, they may just simply become more efficient in the overhead——

Mrs. COLLINS. If the size of the programs is decreased, wouldn't that mean that there will be a void, an absence of the number of people who could be coming in and providing good quality medical care to keep a very high standard of medical performance in our institutions?

Dr. DESMARAIS. Again, it depends on what's going on in that individual institution. There may not be a need for every one of those specialty positions, for example, to provide adequate care. Again, the overhead expenditures may be uncontrolled at this point. It's something they may well address without actually changing the total size of their programs.

I think there are a number of alternatives available to the individual provider.

Mrs. COLLINS. What are they?

Dr. DESMARAIS. I have been referring to some of them. Adjust the size of their programs or the type of program they have, or simply become more efficient in delivering medical education in that particular setting. We don't believe so.

Mr. NIELSON. What was the impact of that doubling?

Dr. DESMARAIS. I believe the impact of the doubling was a great deal of more money went to the teaching hospitals and whatever, in the absence of the doubling. In fact, some of those teaching hospitals have spoken with some embarrassment about the flow of funds to their individual institutions, saying that that flow of funds is far above what they really ought to be getting, providing the high quality of care they historically have provided.

Mr. NIELSON. I guess those teaching hospitals haven't contacted me. The University of Utah Hospital says the opposite. You think

the half reduction in this particular reimbursement will affect the major large urban teaching hospitals in the United States? Or do you feel they will be able to absorb it rather nicely?

Dr. DESMARAI. We believe they will certainly have to work at restructuring themselves in becoming more efficient. But again the reason we had an adjustment at all was because of a statistical observation, and we are going to continue to recognize that observation, even after we have undoubled the formula, so we will continue to pay more to teaching hospitals than to nonteaching hospitals for the average case that they care for.

Mr. NIELSON. Do you believe that this is a long term savings that you are proposing, or just a short term savings?

Dr. DESMARAI. If the statute undoubles the formula, there will be a long term savings.

Mr. NIELSON. Is it likely in 1987 you will discover that 2 years ago, it was doubled unnecessarily? That we may have made a mistake, maybe somewhere in between might have been the right number? Are we sort of thinking that we hit too high, then we're going to hit it too low? Are we going to keep adjusting back and forth on this?

Dr. DESMARAI. We do not believe that will be the case.

Mr. NIELSON. You mentioned statistical studies. That is my field, so I wanted to be sure we are getting some kind of basis. I am a little concerned about the comments made by Dr. Graham about the GMENAC report changing from 70,000 to 35,000. Any statistician worth his salt who made an error like that would lose his job some time ago.

When is your new study on financial and graduate education going to be completed, Dr. Graham?

Dr. GRAHAM. Let me respond to the first issue that you raised, sir, because I am very well aware that you are a statistician, having been up here several times before.

The difference is not because of a different numerical outcome. It is because those two projections are based on totally different projection methodologies.

Mr. NIELSON. Usually when two methodologies come out with different numbers, there is a way to reconcile them and if you come up with—

Dr. GRAHAM. I will provide you, sir, for the record a description of those two methodologies. In brief, one of them assumes the continuation of present trends in the pattern of care being delivered. One assumes a pattern of care being delivered which more nearly approximates the judgment of the medical profession as to what is needed and appropriate.

And when you make those two profoundly different assumptions, you generate very different numbers in terms of the total number of practitioners that are necessary. We can put two or three-page summaries of that in the record right here.

In terms of the Department's present review of graduate medical education, that is being handled out of the Office of the Assistant Secretary for Planning and Evaluation.

I have seen one status report of that study within the last 3 to 6 months. I believe it is going to be at least another year before that is completed. Let me check, because Mr. Hatch is in the audience.

Our understanding at our agency level is that it will be about 1 year until that study is totally completed for the Assistant Secretary.

[The following information was submitted for the record:]

Methods of Projecting Physician Requirements

There are many ways to approach the projection of health professions requirements. Two of the most well-known and acceptable approaches are those of the Bureau of Health Professions and the Graduate Medical Education National Advisory Committee.

BHPr Method

Projections of requirements to the year 2000 developed by the Bureau of Health Professions use a utilization/demand-based concept that describes the health care system in terms of the expected demand for health care services and for physicians. On this basis, the 1990 and 2000 projections of requirements refer to the quantities of health care which the population may be willing and able to buy and physicians willing to provide. The objective is to provide an understanding of what the future physician situation might be if recent developments continue on their current course, that is, to offer a reasonable picture of what the future could hold on the basis of clearly stated assumptions reflecting a general continuation of recent trends and developments. Thus, these estimates point out what could be, not what should be, on the basis of demand for and utilization of health services.

Specifically, BHPr looks upon the requirements for medical care and physicians as largely an economic decision and treats historical trends in the utilization of medical services as a surrogate measure of consumer demand. The BHPr estimates reflect past trends in health care consumption adjusted for likely future changes in population, age distribution, income, health insurance, and prices. Since per capita utilization has not increased in recent years, the BHPr estimates of physician requirements assume continued growth in the demand for medical services based on population changes. Based on the past trends, physician productivity is assumed to remain unchanged in the BHPr model. If physician productivity turns out to be higher/lower than it currently is, then the BHPr estimates will tend to overstate/understate actual requirements.

GMENAC Method

A different approach to projecting requirements for physicians was undertaken by the Graduate Medical Education National Advisory Committee (GMENAC). The Committee was established in 1976 by the Secretary of the Department of Health and Human Services (then the Department of Health, Education, and Welfare) as an advisory body of representatives from the various agencies and organizations whose functions were relevant to the accessibility and availability of medical services.

The basic philosophy of the GMENAC physician requirements model was to establish national goals for physician specialty distribution using an "adjusted needs-based" approach. In summary, this approach generated physician service requirements as a function of expected national morbidity, first modified by expert opinion of what fraction of this morbidity should require medical intervention, and then modified by estimates of the constraints of the existing health care system.

The term "adjusted" is used to connote several features:

- (1) actual epidemiological and utilization data are adjusted by experts to reflect their judgment of measurement problems or of future trends;
- (2) utilization data are adjusted to incorporate expert opinion on appropriate treatment; and (3) the whole model is adjusted in that the estimates are tempered by knowledge of the realities of provider and consumer behavior as well as by institutional constraints foreseen from the projection period.

In essence, GMENAC estimates future physician requirements on the basis of the Committee's view of the adjusted "need" for medical services: that quantity of services which expert medical opinion believes ought to and can be consumed over a specified time period for persons to stay or become as healthy as possible given existing medical knowledge. Through a combination of empirical data and professional judgment, GMENAC arrives at estimates of appropriate utilization of medical services. In somewhat oversimplified terms, physician requirements are calculated by first multiplying the number of individuals in the population by the total number of morbidity conditions and the appropriate utilization of services per condition for each medical specialty. This product is then divided by the existing average or desirable workload for each type of medical specialist.

Resulting Projections

BHPr

The BHPr model projects requirements for 559,300 physicians in 1990 and for 654,700 physicians in 2000. This represents a 43 percent increase in requirements for physicians over the period 1981-2000. In both 1990 and 2000 the supply of physicians is projected to be greater than requirements. For 1990 an excess of 35,300 physicians is projected, and this figure increases to 51,800 physicians in 2000. The excess represents about six and seven percent of the total supply in 1990 and 2000 respectively.

GMENAC estimated that a total of 473,000 full-time-equivalent physicians will be needed by 1990. It is important to note that these estimates reflect the view of GMENAC about what is needed and required for appropriate treatment, and future economic, social, and behavioral constraints that would affect the overall attainment of the level of services required using the adjusted needs-based approach. Thus, the requirement estimates reflect judgments of what is desirable for good medical care, not necessarily what is or what will be.

Subsequent to GMENAC, and in a new development since the Third Report to the President and Congress, requirements for 6 of the 32 specialties and sub-specialties considered by GMENAC have been modeled using the same adjusted needs-based methodology. These specialties include neurology and the five hospital-based specialties of anesthesiology, nuclear medicine, pathology, physical medicine and rehabilitation, and radiology. In the GMENAC report, requirements for these six specialties were based on a review of relevant literature and could not be modeled as intensively as the other specialties because of timing and resource constraints; however, through a contract awarded to Battelle Human Affairs Research Centers from the Office of Graduate Medical Education of HRSA, the full needs-based approach was applied to develop specialty requirements consistent with requirements estimates developed by GMENAC for the 26 other physician specialties. The refined estimation of these six specialties resulted in decreasing the aggregate projected physician surplus of GMENAC from 70,000 to 63,000 more physicians than required in 1990.

Mr. NIELSON. Would it be wise to propose a change in the financing of graduate medical exam title VII program when that report comes out and we have a better basis on which to base it?

Dr. GRAHAM. I think as a matter of judgment, and then putting together the 1986 budget proposal to the Congress, the President did not feel it was prudent or appropriate to wait that long to make the proposal.

Mr. NIELSON. So on what basis is he making the proposal, then?

Dr. GRAHAM. I think the general reflection in the budget is that with the projected oversupply of physicians—and, indeed, most of the types of health care providers that we can identify—it is no longer appropriate in a time of constrained Federal resources to single out the health professions for special supplementation of Federal revenues.

Mr. NIELSON. Congressman Wyden pointed out one thing I wanted to mention, the care of indigents. One difference a teaching hospital has over a regular hospital is that they do have to take such cases. You are undoubtedly aware of the Hanson twins, Siamese twins who had to be separated. They were joined at the skull. A very elaborate, very expensive series of operations. The University of Utah Medical Center incurred several hundred thousand dollars of expenses in that particular one which are not reimbursed directly.

Since they have to do that sort of thing, and they have these special things, do you feel it is wise to change this DRG indirect medical cost at least for the moment?

Dr. DESMARAIS. In the question you are asking basically it is. Should the Medicare Program which was aimed at the aged population and whose trust fund is in danger, should they be asked to fund uncompensated care for other populations?

I think that's why I have been trying to say the whole issue of uncompensated care, we believe, is a much broader issue. We know it is one that the Congress is very, very interested in.

Mr. NIELSON. Those are all parts of the costs of the teaching hospital, because they learn from these kinds of complicated operations which they have to take on on an indigent basis.

I am a little worried about the doubling effect and why that was doubled without adequate reason or without adequate study, and now why it is being halved, cutting back to the original amount.

It appears to me we need to have more facts on the matter.

How many of these colleges are awash with money, these teaching college hospitals? You said maybe most of them were embarrassed about the surpluses they have. What percentage of them would you say were in that category?

Dr. DESMARAIS. We don't have that kind of information at this time.

Mr. NIELSON. Should we have that kind of information?

Dr. DESMARAIS. I am not sure we would be able to obtain that kind of information.

Mr. NIELSON. I am a little concerned. I want to save money, like everyone else, but maybe we should just cut the funds on those who have too much money or are embarrassed about it.

I am serious. And those which have not found themselves in this embarrassing position perhaps keep the funding. I am not saying you should reward inefficiency or anything of that nature, but let's find out which ones have too much money and why they have too much money and maybe readjust the allocation or do something else. Maybe some of them are better situated for other reasons.

Some of them may be in States where they are the only teaching hospital in the State, they have to take care of all the extra costs of indigent care, things of that nature.

Dr. DESMARAIS. The point, though, is if the regression analysis told you a 5 or 6 percent adjustment was appropriate for those teaching hospitals, and without any further basis it was doubled, all we are saying is we don't believe that was appropriate and I can put a little flesh on what this all means.

We did a simulation and we looked at teaching hospitals to see if we were to pay them strictly out of the Federal prospective payment system and have the current double formula, what would happen. It is in my testimony. But for 118 of the heavy teaching hospitals, the ones with the large programs, that simulation showed us that the average payment would be \$556 per case for the direct medical education, \$4,079 per case for the regular DRG payment, then a 53 percent add-on for each case of \$2,158 for the indirect medical education adjustment.

Second, we are saying it's 195 percent of what the payment would have been for a nonteaching hospital for a particular average case.

Now we are questioning the appropriateness of all that.

Mr. NIELSON. I have no quarrel with you wanting to bring it down to the right number. I have no quarrel with you saying we ought to have the right number. What does concern me is allowing it to double 2 years ago without a murmur, and then come back 2

years later and say we made a mistake, we have got to bring it back to where it was.

I am not sure how much of this bringing it back is because of the fiscal situation, or how much is because—I am not sure it is fiscal or whether it is just trying to recoup ground you lost that you gave without a fight.

There were those of us last year who would have kept it lower if the 11 percent was unjustified.

Dr. DESMARAIS. I think it is fair to say when the hospital's prospective payment system was being debated, we proposed a number of things, and we were concerned about a number of different provisions.

Nonetheless, the Congress felt they were appropriate. This is one provision in particular we feel, based on further analysis and because of our continuing concern about the fact that it was doubled without any particular reason, at least no statistical ground, that we feel it is appropriate now, given the status of the trust fund, given the surplus of physicians, and given the budgetary concern, that we go back, we undouble the formula, and we recognize what we should have recognized to begin with, that we had a statistical foundation to establish.

Mr. NIELSON. Just for my information, if we do anything like that again, double without reason, will you hold off until we make sure we have a good reason for doubling, and let us know how you stand? Because there's always the Senate, the Republican Senate, there's always the veto, there are always these sorts of things, if you just let us know the facts.

Second question I have on your 2 million medical professionals. I have been talking to a good many medical people in my own State, and they report a problem, not too many doctors, so much, and not even the maldistribution of doctors, as you suggest. But they suggest a lot of the extras are not going to go into medicine. Most of their doctors are advising their sons and daughters not to go into medicine because they say they have to freeze their levels, and yet they don't freeze the ingredients that make up their levels. For example, malpractice insurance has quintupled in the last 7 or 8 years.

None of the costs that the doctor has are frozen. Yet his fee is frozen. And they are discouraging the young and bright from going into medicine.

Now if that is a trend—maybe it is localized in my State—but if that is a trend at all, then I worry about cutting off title VII prematurely.

Then my second question—this is a comment—my question is, how do you propose this maldistribution of doctors can be addressed by States and localities, and why do you feel that is a State problem, rather than a national problem?

Dr. GRAHAM. To comment in terms of what we and the medical colleges are seeing to date, in terms of the number of applicants, is a slight drop in the total number of applicants available for first year spaces, but not a profound drop.

I have heard some anecdotal stories about individuals in medicine today that say: my gosh, if I had to practice medicine 30 years from now, I sure wouldn't go into it. I don't know how broad and

widespread a view that is going to be. I don't want to minimize in our conversations what in my perception is a very profound phenomena that we are all going to have to deal with in the finite future. And that is in 1984 there are approximately 500,000 physicians practicing in the United States, and already in urban areas we hear about oversupply and competition.

By 1999, there will be 700,000 physicians practicing in the United States. That is a 40 percent increase on the practitioner base in 15 years. That is a type of increase that has never been experienced by any industrialized nation in history, so we are sailing into uncharted waters.

I think there may be some good news, because of the increased number of primary care practitioners that have been trained in the last 10 to 15 years. We are seeing large numbers of those graduates, particularly in family medicine, that are going into the smaller communities, and the subspecialties of surgery and internal medicine and pediatrics: We are seeing subspecialists go into moderate-sized communities where they can establish a viable practice base.

So some of the good news may well be that our public is going to be more adequately served and find physicians more easily in the coming years than they have in the past. But still the number of physicians could become of such magnitude that in 5 or 10 years there will be a question as to whether or not a young person ought to go into medicine. We don't see that in the application rates right now.

Mr. NIELSON. The other part of my question, how is the State going to redistribute these factors? How can the States do that and localities do that?

Dr. GRAHAM. Well, it depends upon the State. Some States have been highly aggressive in terms of setting up individual networks, recruitment systems. North Carolina is one of the best examples that I know of that comes to mind. They have had an office of rural health in North Carolina for 10 years. They have gone out and recruited. They started off with Federal funds for the AHEC Program, and had those for 6 or 7 years. It is now an entirely State-funded operation, and I think North Carolina—although I know they still have communities where they are still trying to get physicians, nurses and dentists, too—is probably farther down the road than any other States.

There are other States looking at that experience and trying to duplicate it. The Federal Government has been able to play a partnership role over the last 10 or 15 years, and, we hope, establish that infrastructure on which the States can now operate.

Mr. NIELSON. Mr. Chairman, my time is now up. May I ask one more question?

Mr. WAXMAN. Yes.

Mr. NIELSON. Congressman Wyden and I talked about some of the things that cost—teaching hospitals have higher costs. Has HCFA been able to accurately quantify the factors that cause these higher costs in determining the indirect medical education adjustments DRG? Have you been able to quantify those?

Dr. DESMARAIS. The regression allows us to quantify the aggregate difference in costs historically. But it doesn't allow us to say it

is because of severity of illness or because of a variety of other kinds of things. There have been a number of studies attempting to disaggregate that cost difference, but they have not been all that successful, and there is a running debate about what is the predominant factor among them.

Mr. NIELSON. To followup Congressman Bilirakis' question about freezing direct medical education payments, if this proposal is done, will teaching hospitals then replace the residents with physicians? Or will they increase the Medicare Part B approach?

Dr. DESMARAIS. Obviously we don't believe that will happen. One of the motivating factors for this proposal is to reduce our budgetary outlays. If we believed we'd be spending that money on the part B side of Medicare instead of the part A side, it wouldn't be much of a saving.

So we don't believe it is going to occur to any extent.

Mr. NIELSON. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Nielson.

Mr. Richardson.

Mr. RICHARDSON. Thank you, Mr. Chairman.

I just have one question. Let me just state for the record that I think this is an important hearing. In trying to learn about these issues, you recognize the complexity. I have had a chance to work with Dr. Graham on a number of other issues, and I think he is a very strong professional, and rather than make statements about what I think is the meat cleaver approach that is being used to some of these medical education funding options with Medicare and Medicaid, I would like to not do that, and just ask a question relating to particular needs that I have coming from a rural area with large Indian and Hispanic populations, where health care availability is a serious problem.

Some are suggesting that medical education disbursements be provided to ambulatory care settings and to HMO's, rather than just the hospitals, to take into account some of the rural needs of certain areas.

Have either of you two done any thinking of this issue? Is that a possibility in the future? Does that make sense?

Dr. GRAHAM. I referred several times to the types of conversations that we have had with HCFA over the last 5 or 10 years. HCFA does now reimburse the accredited residency programs that do primary care. Some of those costs are encumbered in an ambulatory setting rather than an inpatient setting.

There are slightly different formulas for reimbursement for that, and we feel that we have worked out a reasonable accommodation with HCFA in terms of our narrow interest around the primary care programs and HCFA's interest in terms of total outlays from the trust fund, to make sure that there is some reimbursement for that.

It is, and I would say will be, an ongoing issue between us and HCFA of how, given whatever the principles and priorities that HCFA is following for reimbursement and disbursement out of the trust fund. We can, consistent with those priorities in the overall administration goals, seek ways to emphasize reimbursement for primary care residency programs.

I feel we have a good working relationship with HCFA, and I would anticipate that that would continue.

Mr. RICHARDSON. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Richardson.

Gentlemen, we appreciate your outlining the administration's position for us. We want to explore those issues in more detail. They are more complex. The fact that we are paying into teaching hospitals, recognizing the fact that they do something other than just provide care that other hospitals provide, so we give them more money to represent the teaching costs, to represent the patient population that they serve; the fact that some of those patients need greater care or more intensive care; and that as we discuss all these things we are talking about, we have to keep in mind what policy outcome are we going to have on the distribution of physicians, both by specialty and by geography.

I guess Mr. Nielson put his finger really on the question that bothers me. As we look at all policy questions, do we know enough information and do we know what the impact will be. If a doubling of the factor was arbitrary and not valid, isn't a meat ax approach that simply cuts it in half just as arbitrary?

Maybe we can't do anything more sophisticated, but it seems to me in terms of the policy implication, what we are doing here by these proposals is a very crude way of addressing a lot of very difficult and complex issues. It may be the best we can do. It may just be a dollar amount that we have to apply across the board, and maybe we can find out some other ideas on how we can mold these policy issues in a way that addresses these questions and also make sure we are using the taxpayers' dollar as effectively and frugally as possible.

In the course of this inquiry, I am sure we are going to have additional questions to ask both of you, so I would like to have the opportunity to submit questions to you in writing, so we can have you respond for the record.

Dr. DESMARAIS. Certainly, Mr. Chairman.

Mr. WAXMAN. Our next witness is Dr. Robert Heyssel, president of the Johns Hopkins Hospital Administration of the Johns Hopkins Hospital.

Dr. Heyssel, we want to welcome you to our committee hearing today. Your prepared statement will be made part of the record in full and we'd like to ask, if you would, please, to summarize that statement. Try to keep it around 5 minutes.

STATEMENT OF ROBERT M. HEYSSEL, M.D., PRESIDENT, THE JOHNS HOPKINS HOSPITAL

Dr. HEYSSEL. Thank you. Chairman Waxman, members of the committee, I am pleased to have the opportunity to be here. I want to make a comment first on the question of cost as it relates to direct medical education.

It has been commented already that is a relatively small sum of money, and freezing it will have small impact, although all amounts of money are important.

However, what is not addressed in simply freezing are questions of specialty numbers or training specialty distribution. I cannot

predict the outcome of that. I think it can be noted that over the past few years the number of people in specialty training and subspecialty training have not declined at all.

It may well be that the opposite effect would be that people would choose to train more people like that, rather than primary care specialties.

So one of the problems with the proposal is it doesn't address that problem at all. The administration's proposal, however, to reduce the indirect medical education adjustment by 50 percent is an issue that goes far beyond Federal support for medical education.

It has already been stated when the indirect medical education adjustment was added to the DRG rates to teaching hospitals, that was a proxy to take into account a number of functions which legitimately increased costs in teaching hospitals.

It captures a lot of factors that simply have nothing or very little to do with medical education. The Commonwealth Fund Task Force, of which I am the chairman, has commissioned a report that includes a fair amount of analysis on the components of the indirect medical education allowance.

While they are not yet available for final report, we believe we can demonstrate there are several factors included in indirect medical education adjustment that are inappropriately tied to one of the products of the teaching hospitals, that is residents. Amongst them are severity of illness, patient mix and diagnoses within individual DRG's, and certain socioeconomic characteristics and population characteristics of patients that teaching hospitals care for.

I would simply say it costs more money to take care of poor people than it does the middle class, many more support services, and they are more commonly ill. And, to the extent teaching hospitals are involved in that, the DRG adjustment that is currently in place is a proxy then for free as well as direct medical education.

The adjustment further enables certain hospitals to continue to function as regional referral centers providing technologically advanced services and is used to support emergency standby services which Medicare participants receive, such as trauma care or burn units.

Concern with escalating costs in general has focused attention on the appropriateness of the graduate medical education function, specifically, the problems of size and content.

Certainly the open-ended financial support of GME that we have had in the past provides little or no incentive to change. Instead of freezing Medicare payments for direct medical education, the committee might consider having Medicare fund graduate medical education for a finite period of time, either 3 years, or to the point at which a resident becomes eligible for board certification in a general specialty area.

That range is from 3 to 5 years in the surgical specialties.

The rationale for advocating a level of support equal to the cost of 3-year training is to establish a finite limit and to have that limit coincide at least with board eligibility in the primary care specialties.

In effect, we would be funding generally accepted minimum competency levels in primary care specialties and allowing people and

the programs to make their own decisions concerning indebtedness or sponsoring of programs associated with going into subspecialization.

This sort of control, I believe, has more opportunity to succeed than simply dealing with numbers and trying to decide how many people should be in what specialty.

In my testimony I have a rather complicated chart that relates to control of graduate medical education. I will not go into that at this point, except to simply point out that the funding mechanisms and the complicated control systems in the private sector are such that those who make decisions concerning content and size of graduate medical education are divorced from the payment mechanism which generally falls back on the teaching hospitals in the locality.

It seems to me that there needs to be a way to bring the private sector into better communication with those who pay.

I would like to make two other points for you. First, as you examine the role of Medicare and the support of GME, note that it supports only one-third of all graduate medical education.

That one-third really reflects the fact that about a third of the patients in the hospital or the dollars going to the hospital come to Medicare.

We have in effect a very broad base of participation through an indirect contribution from all payers. This system of funding is very vulnerable to changes in payment policy or practice in the private sector as well.

Changes in Medicare reimbursement at a juncture in time in which increasingly private sector payers are opting for the lowest price in hospital care means that funding will be withdrawn by third-party payers of other than Medicare and further jeopardize the system.

Quite specifically, it should be noted that HMO's as an example have participated very little in the funding of graduate medical education over time. So a change in Medicare at this time in history may well bring about much greater effect than anyone has suggested to this point.

In summary, I believe it is appropriate for the Medicare program and all other payers to support graduate medical education. A way must be found to ensure that there is broad participation, because it is a societal good for everyone. However, the financial support should not be open-ended. Some finite limit on the number of residencies and/or use of residency training should be imposed. Control of the design of GME should remain in the private sector, with formal linkages between accrediting bodies and those who pay for graduate medical education established.

Finally, I have suggested an alternative method that is funding a limited number of years, which will certainly have an impact at the very least on subspecialization, I believe, in internal medicine, pediatrics and other primary care specialties.

Thank you.

[Dr. Heyssel's prepared statement follows:]

Testimony

Robert M. Heyssel, M.D.
President
The Johns Hopkins Hospital

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health and The Environment

April 3, 1985

Congressman Waxman, and members of the Committee, I am Dr. Robert M. Heyssel, President of The Johns Hopkins Hospital in Baltimore, Maryland. I appreciate the opportunity to speak with you this morning about graduate medical education (GME). You have no doubt heard much about this subject over the past few months. For the past two years, I have chaired a national Task Force on Academic Health Centers, sponsored by The Commonwealth Fund. Our Task Force has also been very interested in graduate medical education, specifically those problems that relate to its size, its content, and its cost.

First, let me address the problem of cost because I do not believe it to be the most crucial. Aggregate spending on GME has been variously estimated from \$3 billion in direct costs to \$9 billion total cost (both direct and indirect). Medicare's share of that cost is roughly one-third. Measured against total annual spending for

health care (\$400 billion), GME represents a small percentage, and the savings generated from the Administration's proposed freeze of direct payments are not likely to significantly improve the fiscal position of the Medicare hospital trust fund.

The Administration's proposal to reduce the indirect medical education adjustment by 50% is an issue that goes far beyond federal support for medical education. When the indirect medical education adjustment was introduced into the prospective payment legislation, Congress clearly stated that this adjustment was "a proxy to account for a number of functions which legitimately increase costs in teaching hospitals." This adjustment captures factors associated with operating a teaching hospital that are not a function of graduate medical education. The Commonwealth Fund Task Force has commissioned a report that includes a fair amount of analysis on the components of the indirect education allowance. Although our findings are not yet available in final report format, we plan to demonstrate that there are several factors included in the indirect education adjustment that are inappropriately tied to the education product of teaching hospitals - among them, severity of patient illness within teaching hospitals, - a more resource-intensive mix of diseases within each DRG that are not reflected in case mix measures, and certain socioeconomic characteristics of a patient population that

have implications for severity of illness and hospital length-of-stay. I urge you not to distort the political debate about the financing of graduate medical education by viewing the indirect medical education allowance as financial support for the educational mission of teaching hospitals. The adjustment enables certain hospitals to function as regional referral centers, allows some hospitals to make available sophisticated, technologically-advanced services, and also is used to support emergency, standby services such as specialized intensive care, trauma care or burn units. In fact, The Task Force analysis uses regression equations to demonstrate that the indirect education adjustment is more a function of special patient care services than education.

Concern with escalating costs in general have focused attention on the appropriateness of the graduate medical education function, specifically the problems of size and specialty distribution. Support for GME should not continue to produce physician manpower that does not match the medical needs of this country, in terms of both absolute numbers and specialty distribution. Open-ended financial support of graduate medical education provides little or no incentive to reduce the number of physicians trained in this country or to encourage graduating physicians into selecting shorter (less expensive) residency training programs in the so-called primary-care specialties.

Instead of freezing the Medicare payments for direct medical education, the Committee might consider having Medicare fund graduate medical education for a finite period of training - either three years or to the point at which a resident becomes eligible for board certification in a general specialty area (ranges from three years in the primary care specialties to five years in the surgical specialties).

The rationale for advocating a level of support equal to the cost of three years' training is to establish a finite limit and to have that limit coincide with board eligibility in the primary care specialties. This kind of a limit might provide incentive for fewer internists to subspecialize in gastroenterology, for fewer pediatricians to pursue advanced training in pediatric cardiology, and as another example, for fewer doctors to enter the lengthy training programs in the surgical specialties. In effect, we would be funding generally accepted minimum competency in primary care specialties and allowing people and programs to make their own decisions concerning indebtedness or risk associated with going on into subspecialization. This form of market control, I believe, has a much better chance of yielding a proper mix of specialties than does freezing Medicare payments.

However, most important to the problems of cost, size, and specialty distribution is the problem of control.

(Refer to Chart)

I will try to simplify what is actually a complicated system of design and control for graduate medical education programs. The Accreditation Council on Graduate Medical Education (ACGME) establishes general requirements for GME programs and authorizes residency review committees (RRCs) to review and accredit individual programs in graduate medical education. Each residency program must conform to the set of general requirements and to special requirements established by the residency review committee for its specialty. These requirements generally concern faculty, administration, and program content. Each RRC also determines minimum program length ranging from three years in the so-called primary care specialties to seven years in thoracic surgery.

Independently, medical specialty boards establish the educational criteria that residents need to achieve to be considered for certification in a given specialty. The specialty board recognizes individual physicians (as opposed to residency programs) who have met requirements specified by the board and who have successfully completed an accredited residency program. As you can see, the potential

exists for a medical specialty board to require a longer period of training for board certification than a residency review committee would require for accreditation of a GME program.

The reason I bring this to your attention is not to confuse you. The fact is that the accreditation process for residency programs and the certification process for practicing physicians is carried out in isolation from the financing of graduate medical education. Payors for medical care, who support graduate medical education, have no clear voice in decisions that affect the design and content of GME programs - decisions that have ramifications for the cost of health care and for the financial status of teaching hospitals.

To control the absolute numbers of physicians trained in this country, some mechanism beyond the forces of market demand should probably be introduced. One alternative is to distribute GME positions to graduates of medical schools through a system of vouchers. Distribution can be limited to graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME). When such a system is applied with the three-year option described earlier, Medicare's financial responsibility is reduced to a level that provides funding for three years of graduate medical education for each medical student graduating from

an American medical school. Using the number of students who graduated from LCME-accredited medical schools in 1983 (15,885), the number of total positions receiving partial support through Medicare would be equal to three times the number of annual graduates or 47,655 positions. Currently there are some 76,000 residency positions, including roughly 7,800 funded through the Veterans Administration.

Let me underscore two important points made earlier for your consideration as you examine the future role of Medicare in the support of GME. I noted that Medicare supports approximately one-third of graduate medical education training - that one-third reflects the fact that over 80% of all funding for GME flows through hospitals and that Medicare pays for approximately one-third of all hospitalized patients. Since Medicare, Medicaid, and all other third party payers support GME, we have in effect, a very broad base of participation through an indirect tax or contribution from all payers. This system of funding is very vulnerable to changes of payment policy or practice in the private sector as well. Mechanisms to assure their continued participation are paramount in any consideration of changes in funding or control of GME. The role of states in these decisions and arrangements is also important and merits careful evaluation.

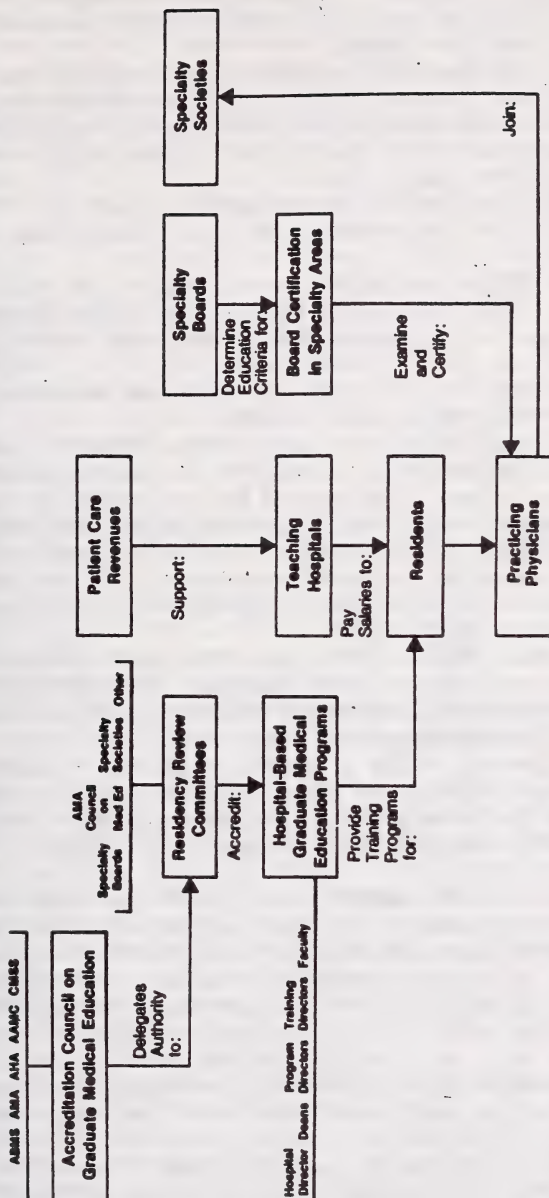
Second, while graduate medical education is the term applied to the residents in training, the fact is residents render essential services in our hospitals. The point to be emphasized is if residents were not rendering these services, someone else would have to do so and, in some instances, probably at greater cost.

In summary and in conclusion, I believe it is appropriate for the Medicare program and all other payers to support graduate medical education. However, that financial support should not be open-ended and some finite limit on the number of residency slots and/or years of residency training should be imposed. Control of the size and design of graduate medical education programs should remain in the private sector but formal linkages between accrediting bodies and those who pay for graduate medical education should be established. Finally, I have suggested an alternative mechanism to distribute funds for graduate medical education - a voucher system. A resident would receive a voucher to be used to purchase his or her medical education - limited to three years of support or first certification in a specialty area. Teaching hospitals could recruit residents carrying vouchers based on those specialties they felt they could adequately provide training in and for which they had received accreditation. Market demand would continue to determine the distribution of physicians across specialties, complemented by incentives for medical students to choose shorter training periods.

I appreciate your time and your attention.

Thank you.

Control of Graduate Medical Education



Mr. WAXMAN. Thank you very much, Dr. Heyssel.

Can you tell us when the results of the Commonwealth Fund Task Force will be released?

Dr. HEYSSEL. Probably in terms of graduate medical education, in late April, early May. Probably in terms of financing of teaching hospitals, a study done of the indirect medical adjustment and done by Dr. Anderson, who will be here subsequently testifying, probably in late May, early June.

Mr. WAXMAN. Let me ask you certain questions I know you have discussed in your statement, but just to underline some of these points.

First of all, do you believe we are training the right number and right mix of doctors? And is there a bias in the financing arrangement in favor of subspecialized medicine and against primary care medicine?

Dr. HEYSSEL. No, sir. I do not think we are training the right numbers or the right mix of doctors.

Second, yes, I do believe there is bias. 80 percent of the funding, approximately, really is focused on the teaching hospitals of the country, and about 50 percent of that is focused on about 100 institutions which really train 50 percent of the residents in the country. Since the payments come through the hospital, their flexibility, as an example, in funding residents' positions outside the hospital where it might be more appropriate in ambulatory care and so forth is severely limited.

As I noted, HMO's have not been participants to any major degree in graduate medical education, and medical schools have generally not had the resources to fund graduate medical education programs in settings outside the hospital.

About the only really successful approach to that has been the family practice programs which have in fact been subsidized outside of the Medicare third-party payer system. So, yes, it does tend to bias both the training programs and, I think to some extent, choices.

I commented on subspecialties in internal medicine, you know, fellows in the country are funded about 60 percent again through the hospitals. Many of those clinical fellows who go on to subspecialization in internal medicine, because those subspecialties such as cardiology, which have the opportunity through the fee system to earn large amounts of money, can subsidize fellows much easier than some other subspecialties which don't have that opportunity.

Mr. WAXMAN. If you were trying to reshape Medicare and Medicaid policies in some fashion to try to influence more specifically the manpower and health policy effect, where should be the focal point of our efforts to get some leadership and coordination in the implementation of these policies? What should we be doing?

Dr. HEYSSEL. I have suggested that, one, we limit the number of slots that we be paid for by all payers.

Second—and I will come back to the all-payers issue—

Mr. WAXMAN. Before you leave that one, you would limit the number of slots by saying we will only pay for a certain number of slots?

Dr. HEYSSEL. Only a certain number of years times, for instance, the number of graduates. For example, for LCME-approved schools

in the United States. So as an example, that could be at a minimum 45,000, since there are about 15,000 graduates times 3 years. And if one then wanted to make some adjustments, for instance, to go to first accreditation as an example in the surgical specialties, which would be 5 years—I don't have the exact numbers, but it would be something greater than 45,000, but considerably less the 76,000 we have today in residence training programs.

Mr. WAXMAN. How would you deal with the all-payers question?

Dr. HEYSSEL. That is a much more difficult situation. What one would like to see is all payers at least pay into a fund separated from the hospital. Perhaps you can have a voucher system that an LCME graduate, for example, could apply for, for residency training and draw on the pot of money to be paid for 3 years and take it to wherever he is accepted as a resident.

That requires a much broader approach to the problem and in effect a mechanism for taxing one way or another all premium income, and as the insurance market has gotten fractionated, it and so many corporations are now self-paid through benefits administrators and so forth, it becomes a much more difficult thing to do.

I would hope that perhaps at the State level there might be another solution found if Medicare participated on that basis state by state.

A Florida solution for poor care is one way to look at that, in which all hospitals be taxed on every admission.

Mr. WAXMAN. With the pressure on all payers to try to reduce the amount of expenditures, do you see a move away from using the teaching hospitals for privately-insured patients by those private insurers and by their employers who provide that insurance coverage?

Dr. HEYSSEL. I don't think there is any question that that will occur, Chairman Waxman. In fact, it is occurring in many areas today. A PPO and HMO, given the choice of two hospitals for relatively routine care, one of which supports only the medical care aspects and the other of which has a broad mix of patient standby services, has in its residency training programs, is as a matter of price alone going to choose the hospital which is lower in price and does not produce those other products.

And every time that happens, the broad base of support for what has been one of the best systems in the world, of graduate medical education, if not the best, is eroded.

Mr. WAXMAN. Not only is the broad base of support eroded, but the government application would be increased.

Dr. HEYSSEL. That is true.

Mr. WAXMAN. As the patients that were going to go to these teaching hospitals where there is some public assurance of the Medicare-Medicaid patient. So if the Federal Government wants a teaching hospital to carry on all these complex roles that they now assume, the Government is going to have to pay for it.

Dr. HEYSSEL. That is correct. You know, I don't really have the number, Congressman Waxman, but my guess is that in view of the complexity of the illness of older people, they are very likely to end up because of the diseases they have in hospitals which can provide tertiary care services. You remove from those hospitals a

significant proportion of other kinds of patients that are funded by other payers, then the net result can only be an increase in cost to Medicare, Medicaid and other patients.

Mr. WAXMAN. The administration witnesses have told us that all these factors go into this extra reimbursement we give to teaching hospitals, and they cannot isolate the various factors, but they feel a factor that was agreed upon in 1983 was just too generous. Some hospitals are awash, teaching hospitals are awash in money and are embarrassed by it.

Therefore, they feel we ought to just cut it in half. What do you think would be the effect of the President's proposals on teaching hospitals?

Dr. HEYSSEL. It is my understanding—and here I don't have the facts at my fingertips—that in 1983, when the factor was doubled from 5.87 to 11.8, or wherever it is at the moment, that in fact an analysis was done and it was determined some place in Washington that the 5.87—

Mr. WAXMAN. Then it must be true.

Dr. HEYSSEL [continuing]. I wouldn't dispute that. That 5.87 would not cover many teaching hospitals around the country, and a number larger than that was required if you use residents per bed as your proxy for measuring the differences between costs by DRG between teaching hospitals and other hospitals.

It was not my understanding that it was simply whimsy that led to the decision to double it. That, in fact, it looked like we were going to do something pretty drastic to a whole lot of teaching hospitals. A proposal to now have it seems to me to go back to where we were before may be whimsy or cost savings.

In terms of embarrassment, I know some people who are rolling in money but don't seem to be embarrassed.

Dr. HEYSSEL. But I don't think that is the situation across the country completely. And while the 11 percent or 11½ percent may not be exactly the right number, from everything I know about the situation, it is unlikely that 5.87 is the right number on the low side, either.

Mr. WAXMAN. It seems to me that we just don't know the answers to some of these questions, and we put the DRG system in place or started the process toward that prospective payment system, we are making a lot of guesses, and we hope even as of this time we are getting the right answers as we go along, and hopefully do not too many harmful things to the institutions that serve the American public for their health care needs.

What impact do you think it has on these hospitals when we change our minds every couple of years as to what we think they need, when we are only guessing? We still don't have any information from 1 year to the next as to exactly what these various dollar numbers represent in terms of the extra needs of these teaching hospitals.

Dr. HEYSSEL. Well, uncertainly makes management difficult and it can lead to decisions which ultimately prove to be wrong and are even harmful.

Mr. WAXMAN. That's called the market system adjusting to the amount of money we give them.

Dr. HEYSSEL. That's right. And I think to this point, at least, one can't argue that teaching hospitals in large numbers have been harmed.

On the other side, the effects of what is happening now on the private payer system, coupled with what is happening with Medicare with a cut like this, I believe could lead to some decisionmaking which would be not in the best interest of patients, the regions within which hospitals are located, or anything else.

After all, if we cut the money back in one pocket, no matter what you call it, and someone is beginning to have a real budgetary crisis, you can make a decision you will take care of fewer poor folks, you cut the quality of those services to the poor people, and you can cut back training programs which may or may not be appropriate, and you may not cut back training programs in relationship, incidentally, to medical need within the community. You may cut them back in relationship to where the money is coming from.

Just to put it bluntly, there is little money in an outpatient department taking care of poor people in an inner city. The money is on the inpatient side, and if it's revenue enhancement you are looking for, you don't increase the number of primary care specialty residents in the outpatient department.

As a matter of fact, the smart administrator will close it down or make it difficult to get in.

So these kinds of uncertainties and the amount of change going on in the system now, if forced too rapidly, could lead to decisions which could hurt the medical education system, will hurt medical care for a lot of people, and it will be pretty hard to put back together. It is a cutback on something like the outpatient care part of the teaching hospital's responsibility.

Mr. WAXMAN. Would it be fair to assume that that means we are going to be paying more for some of those patients because we are going to be treating them as inpatients?

Dr. HEYSSEL. Yes, it is fair to say that.

Mr. WAXMAN. So we may think we are saving money, but it may turn out we are not saving any money at all.

Dr. HEYSSEL. Well, you know, a lot of poor people are sort of considered by some people to not have any financial responsibility, not care: they come for medical care and they don't pay because they don't want to pay.

The facts are they don't pay because they can't pay, first. And second, being poor and having pride are not things that can't go together. So people will not come and take charity care sometimes. I think I could demonstrate where that is a major problem, and that occasionally intervention—and diabetes is an example which can lead to hospitalization—doesn't occur when it should.

There is a study—I think I should be fair—a Rand publication which I just saw that indicated that there was only some modest effect on whether it is free care or not free care. I don't know whether I really agree with that, but there was some effect, for instance, on hypertension if the free care was there for those who can't pay.

Mr. WAXMAN. Thank you very much.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Dr. Heyssel, I commend you, sir, for great testimony. You are quite a communicator. You have done a great job as far as I am concerned. I am looking forward, as I am sure is the rest of the committee, to the analysis report you referred to in your testimony.

I am not sure if it is going to arrive in time for the 1986 budget, but certainly hopefully it will be timely in the overall picture.

In that analysis, have you explored changing the reimbursement method so that outpatient revenues could pay for this training?

Dr. HEYSSEL. No, sir.

Mr. BILIRAKIS. Would you suggest it might not be a bad idea to take a look at that consistent with your testimony?

Dr. HEYSSEL. If a mechanism could be found to separate the funding of graduate medical education to specific in-patient experiences of patients so it would have much more—so that it could be encouraging, for instance, to HMOs to get into the graduate training business—they are also linked to hospitals and so forth—I think that would be a real move forward.

If you look at how to do that, I am neither enough of an economist or enough of a politician to know what works best—

Mr. BILIRAKIS. But you are a medical doctor, and wouldn't working, sir, in an outpatient setting rather than in a hospital during your residency make more sense, especially for primary care physicians?

Dr. HEYSSEL. Certainly some of the experience should be much more focused on outpatient experience, yes, sir.

Mr. BILIRAKIS. And if we do change that reimbursement formula, we could be encouraging more residency in those areas; isn't that true?

Dr. HEYSSEL. That is correct.

Mr. BILIRAKIS. I think that is something, Mr. Chairman, that maybe we should take a good look at.

Sir, I would ask you just a bottom line question, the last question I would ask, but I plan to ask this of all the panels except maybe panel No. 6.

I just don't really know what was the picture as far as medical schools and teaching hospitals were concerned, and let's go into poor people, treating poor people prior to 1965, prior to the mid-sixties when Medicare came into being, when Federal funding for teaching hospitals came into being.

What transpired back at that time?

Dr. HEYSSEL. I would like to tell you I can't remember, Congressman, because I wasn't there, but that is not the case.

In fact, I think one would have to say that the Medicaid and Medicare Programs coinciding also with a great increase in private health insurance provided funds for hospitals to do things they had never done before, both in terms of capital expenditure but also extension of programs to the community in ways that had not occurred before.

Second, there is no question that the more adequate funding of hospitals allowed expansion of training programs, and incidentally in response to the expansion of the number of graduates coming out of medical school, which was a national policy, and it clearly

fueled the injection of much of the technology we see today on a broad basis.

The other hard fact is that poor people under Medicaid—and I think many older people could be classified as poor people prior to the institution of Medicare—in terms of medical care services were able to get medical care services on a timely basis they never were before.

It is easy to say, like it is all social programs where we spend all this money: And what do we have? Well, I think what you have is much more equitable distribution of a societal good. Poor people are able to go see a doctor on about the average basis of the middle classes. As a matter of fact, that has occurred over the last few years.

Further than that, there are some indicators, real indicators that that makes a difference. The data I don't have with me, but I have seen data that was put together by, I believe, Dr. Robert Blendon of the Johnson Foundation, which clearly shows that lower death rate of meningococcal meningitis today is very much tied to the institution of Medicaid.

Now, that happens to be a good indicator because it starts like a simple sore throat or cold. You don't go anywhere for that if you don't have much money. Now they go to the doctor earlier.

I think it has made an enormous difference in health for the people. It has also created problems in cost.

Mr. BILIRAKIS. In the interest of time, since I would hope that question will be answered by all of the other panelists, Mr. Chairman, I will quit at this point.

Mr. WAXMAN. Thank you very much.

Mr. Nielson.

Mr. NIELSON. Dr. Heyssel, I appreciate your coming. I think you put your finger on one reason why the teaching hospital has a higher percentage adjustment than the nonteaching hospital, 5.89 to 11.78 or whatever it is, because it does cost more to take care of the poor, and the teaching hospital has a disproportionate number of poor that they have to take care of.

So there was some reason, probably, to raise the 5.89 to some other figure. Apparently, the doubling, it was sort of arbitrary, as has been indicated. Where between the 5.89 and the 11.78 do you think it ought to be? If one was way too low and didn't account for the different mix that you had to deal with, and the other has left you and others embarrassed with riches, where in between do you think it ought to be?

Shall we try to approximate a little better than either of those two places?

Dr. HEYSSEL. I can not answer the question in terms of the specific number.

Mr. NIELSON. I don't think you can because we don't have numbers.

Dr. HEYSSEL. I think there are some analyses that get you closer to where we ought to be. The DRG's themselves, obviously, don't do the job between teaching hospitals and nonteaching hospitals. So some sort of an adjustment has got to be made for those other kinds of services.

There are some factors that are probably measurable, and they may be proxies for some of the same thing. But as an example, location in an urban area and not out around the Beltway in an urban area—I'm talking about poor city—clearly has an impact on cost, as just one example. That is over and above the labor index.

We might be able to provide some of those data to the committee ahead of time, and can, I think, and will.

Dr. HEYSSEL. I would not hazard a guess as to the specific percentage.

Mr. NIELSON. It has been alleged by some that the teaching hospitals don't do a very good job at collecting the money. They let the accounts run 80, 90, to 120 days instead of tidying them up and collecting them in a timely fashion. In other words, the collectables at some major hospitals are 60 to 80 days, whereas the teaching hospitals, it's more like 90 to 120 days.

What has been done to maybe get the payments in a little faster, get a better cash flow in the teaching hospitals?

Dr. HEYSSEL. I think that is a generalization that probably wouldn't hold up if severely scrutinized.

Mr. NIELSON. It holds in 11 Western States, I can tell you that.

Dr. HEYSSEL. I can't speak to that. I simply know the teaching hospitals that I am familiar with generally have collections around the rates that you are talking about, 60 to 80 days. Incidentally, every hospital in the country is under pressure on the accounts receivable side because of a lot of pay or changes.

The latest figures I saw for a very large organization, most of which are teaching hospitals, were around 80 days. I think one has to take into account certain differences between teaching hospitals. That is, those State-owned university hospitals commonly, because of other kinds of problems within the collection systems and so forth, may have a little longer period.

But I think there has been an enormous change in the management of hospitals of all kinds under the pressure of payment changes and so forth over the last 5 years.

Mr. NIELSON. Two quick questions. You mentioned the HMO does not really promote and foster graduate education, and it doesn't really pay its share. You indicated all providers ought to pay more to train medical personnel. How would you propose to do that?

Dr. HEYSSEL. One way I guess it could be done—and this gets you into sort of our national taxation system, and I don't know whether you could find a way to administer it—would be to tax all insurance premiums and all organized, probably, ERISA-sanctioned programs and HMO's in some way.

Another would be to, at the more local level to place a tax on every hospital admission. That has been called a sick tax, but it really isn't, in my judgment, since at one time or another most people end up going to the hospital, unfortunately. It is there as a common good to train health manpower. That is more of a State level program.

Short of something like that, I don't have any way to generate that fund, but I am terribly concerned that the private payers are going to walk away from the problem and that is going to shift more cost back to Government if Government is willing to take it.

Mr. NIELSON. I think that is a good point. I'm glad you raised it.

You also mentioned that the control of the number of physicians and the distribution of those physicians by specialty ought to be in the private sector. How do you plan to do that? How could you achieve that?

Dr. HEYSSEL. I commented on that because I have absolutely no confidence in the ability of any group of people that I could choose, in or out of Washington, to decide what the specialty mix is that we need, either by primary care specialty or otherwise. Therefore, I would like to find a way to let people make their own choices.

It clearly is difficult today as a general surgeon to go into most large urban areas, hang out your shingle and make money these days. Second, if the HMO movement goes to where anybody could make a guess, they don't really have that much use for a lot of neurosurgeons, et cetera, et cetera. They are much more interested in primary care specialists.

So as a matter of employment choice, I think people will make choices and the private sector will adjust from the market forces alone. So that is where I think we ought to go, sir.

Mr. NIELSON. I was also interested in your comment—I won't ask for a response here—about limiting the number of slots in medical schools, emphasizing the first 4 years of medical school rather putting all the money into advanced training. Do you feel that will give you a better total medical care, putting your dollars there rather than in specialties?

Dr. HEYSSEL. I don't think I was speaking of medical school. I was tying the number of funded positions throughout the system to the number of graduates of LC&E-approved schools.

Mr. NIELSON. I see. Thank you.

Mr. WAXMAN. Thank you very much, Mr. Nielson.

Dr. Heyssel, we appreciate your testimony. I think you have given us a different perspective than what we had from the other panel, and now we will hear from others, as well. We look forward to working with you.

Thank you very much.

We are now going to go out of order and take for the next panel before we break for lunch the panel that is listed as panel No. 5, Dr. William D. Deal, dean of the College of Medicine, University of Florida; and Dr. Frank Ridick, Jr., M.D., medical director of the Ochsner Clinic; Stuart J. Marylander, representing the American Hospital Association and president of Cedars of Sinai Medical Center.

We want to welcome the three of you to our subcommittee hearing. Your prepared statements will be made part of the record.

My colleague here, Mr. Bilirakis, indicated Dr. Deal was one of his constituents, and I want my colleagues on the committee to know that Mr. Marylander is one of my constituents and a very respected man in our community.

We are pleased to have you gentlemen with us.

Dr. Deal, why don't we start with you.

STATEMENTS OF WILLIAM B. DEAL, M.D., MEMBER, GOVERNING COUNCIL, SECTION ON MEDICAL SCHOOLS, AMERICAN MEDICAL ASSOCIATION, AND FRANK A. RIDDICK, JR., MD., CHAIRMAN, COUNCIL ON MEDICAL EDUCATION [AMA]; AND STUART J. MARYLANDER, CHAIRMAN, SPECIAL TASK FORCE ON FINANCING GRADUATE MEDICAL EDUCATION, AMERICAN HOSPITAL ASSOCIATION

Dr. DEAL. Thank you very much, Mr. Chairman.

My name is William Deal. I am dean of the College of Medicine at the University of Florida and a member of the Governing Council of American Medical Association Section of Medical Schools.

Testifying with me today is Dr. Frank Riddick, Jr., medical director of the Ochsner Clinic in New Orleans, LA, and chairman of AMA's Council on Medical Education. Accompanying us is Harold M. Peterson, director of the AMA's Division of Legislative Activities.

The AMA is pleased to have the opportunity to testify before this committee concerning Federal funding of health professions education and training.

Mr. Chairman, the U.S. medical education system, both undergraduate and graduate, is second to none and it is an essential component for assuring high quality health care for the American people.

Federal support for medical education has been an important factor in achieving this level of recognition. The administration has proposed elimination of all institutional support for undergraduate medical education.

The AMA encourages continued limited Federal assistance for medical schools. We support continued Federal aid for rehabilitation and renovation of medical school facilities, special projects and schools in severe financial distress. Such assistance will enable medical schools to meet the continued objectives of improved programs designed to meet future health care needs of all populations.

Assistance to schools in severe financial distress should be continued but limited in duration and provided only for schools with unique attributes that would be lost if the school closed.

Another area where Federal Government can provide necessary assistance is the support of special projects within medical schools. Such aid supports innovations in medical education that, once demonstrated, can be used in other institutions as appropriate.

Authority to support such special projects should be broad enough to encourage the development of projects that meet unique and integrated needs.

The administration's fiscal year 1986 budget also proposes significant cuts in loan assistance available to medical students, including the Health Education Assistance Loan Program and a guaranteed Student Loan Program, or GSL Program, the Health Professions Student Loan Program, or HPSL, and Essential Financial Needs Scholarship Program.

The AMA is concerned that the administration's proposals would have the effect of placing medical education beyond the financial availability of students from low- and middle-income families. Cur-

rently GSL loans are the primary source of financial aid for medical students.

If Congress enacts the administration's proposal to restrict GSL funds along with its proposal to reduce the aggregate amount of new HEAL loans and provide no funds for the HPSL and exceptional financial need grant programs, the opportunity to pursue a medical education could be put out of the reach of many students from low income and middle class families.

The AMA strongly supports the availability of adequate financial assistance to students in order to ensure that access to a medical education is not limited to the wealthy.

We also strongly support and encourage vigorous efforts to collect on any delinquent loans or guarantees by the Federal Government.

Mr. Chairman, Dr. Riddick will now continue our testimony and discuss graduate medical education.

STATEMENT OF FRANK A. RIDDICK, JR., M.D.

Dr. RIDDICK. Mr. Chairman, the existing system of financing graduate medical education and training is complex. Changes must be carefully evaluated and considered since any change will affect the Nation's ability to train qualified physicians in sufficient number to meet the health needs of the nation in the future.

Until an appropriate alternative is developed, the AMA strongly supports the current system for financing the majority of graduate medical education costs to patient care revenues from third-party payers, including Medicare.

A key benefit of the existing system is a stable financial environment it has fostered. We are, therefore, concerned about proposals to restructure or dramatically reduce the funding of graduate medical education because no stable alternative funding sources have been identified.

Without adequate and predictable financial support, teaching hospitals will be forced to choose between to undesirable alternatives: eliminate essential teaching programs that are an integral part of the system that provides care for the sick, or face large revenue shortfalls.

The AMA supports continued Federal assistance for residency programs in the areas of family medicine, general internal medicine and general pediatrics under title VII of the Public Health Service Act.

The programs were initiated by Congress to place greater emphasis on training these primary care specialties, with the widespread belief that the number of primary care physicians should be increased. It would be inappropriate to eliminate funding for these residency programs.

Moreover, abrupt withdrawal of support for present programs could be highly disruptive and impede development of manpower in the primary care areas of practice.

The AMA opposes the reductions in graduate medical education funding proposed in the President's budget. We are particularly concerned over the proposed 50 percent cut in indirect medical edu-

cation costs. Many inner-city teaching hospitals have provided substantial amounts of care to the poor and would be severely affected.

We also believe it is premature to alter hospital reimbursement until sufficient data are available concerning the impact on hospitals of the recently implemented prospective payment system. This is particularly true in light of the fundamental flaw in the DRG system, the failure to reflect severity of illness in case mix differentials.

There have been suggestions which would address perceived imperfections in graduate medical education, manpower supply and specialty distribution through changes in funding by the Medicare program. AMA believes Medicare funding is not the proper vehicle for the solution of these problems.

The AMA believes strongly that an indepth study of the financing of graduate medical education should be undertaken before Congress considers major alternatives. To this end, AMA has established an ad hoc committee which will conduct a thorough study of the financing of graduate medical education.

In conclusion, Mr. Chairman, in order to ensure that medicine does not become the province of the wealthy, we believe that the administration's proposals concerning the HEAL, GSL, HPSO, and Exceptional Financial Needs Scholarship Program should be rejected. We also support targeting resources to assist medical schools in maintaining and improving their programs.

In addition, we are extremely concerned over proposals for significantly changing the existing system of financing graduate medical education before satisfactory alternative sources of funding are identified. The system of financing graduate medical education is complex and changes must be carefully considered.

Precipitous action could undermine not only our graduate medical education system but the quality of our health care system as a whole. We urge Congress to continue its long-standing commitment to quality medical education and ensure that the Federal Government Program continues to pay its fair share of the cost of the medical education system.

Mr. Chairman, thank you for providing us this opportunity to testify. Dr. Deal and I would be happy to answer any questions members of the committee may have.

[Testimony resumes on p. 291.]

[The prepared statement of Dr. Deal and Dr. Riddick follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health and Environment
Committee on Energy and Commerce
United States House of Representatives

Presented by

William B. Deal, M.D.
Frank A. Riddick, Jr., M.D.

Re: Federal Funding of Health Professions Education and Training

April 3, 1985

Mr. Chairman and Members of the Committee:

My name is William B. Deal, M.D., and I am Dean of the College of Medicine at the University of Florida. I am a member of the Governing Council of the American Medical Association's Section on Medical Schools. Testifying with me today is Frank A. Riddick, Jr., M.D., Medical Director of the Ochsner Clinic in New Orleans, Louisiana. Dr. Riddick is also Chairman of the AMA's Council on Medical Education. Accompanying us are M. Roy Schwarz, M.D., Vice President for Medical Education and Science Policy of the AMA, and Harry N. Peterson, Director of AMA's Division of Legislative Activities. The AMA is pleased to have the opportunity to testify before this Committee concerning federal funding of health professions education and training.

Mr. Chairman, the U.S. medical education system, both undergraduate and graduate, is second to none and is an essential component for assuring high quality health care for the American people. Federal support for medical education has been an important factor in achieving this level of recognition. Federal support through the 1960's and 1970's centered on increasing physician supply through efforts to establish new medical schools, provide assistance to expand and renovate existing schools, assist those schools in financial distress, and provide direct and indirect support of students through financial assistance programs including grants and scholarships, loans and loan guarantees. This infusion of federal financial support was highly successful, greatly increasing the capacity to educate increased numbers of medical students. Near the end of the 1970's the need for this same federal support to increase the capacity to train more physicians came under serious question and direct support of medical schools was significantly reduced through the repeal of start-up assistance for new medical schools, other assistance for major new construction activity, and the capitation grant program.

The AMA has reviewed the manpower situation and with the rapid rise in the number of physicians over recent years it can be concluded that continued federal stimulus to further increase the capacity to train new physicians is unnecessary. In our view, moreover, decisions in this area should be dictated, to the greatest extent possible, by market forces -- with government involvement, when appropriate, to carry out its functions in assuring the public health and welfare. That is not to say that government does not have an important role in assisting in funding

medical education today. States, of course, provide substantial amounts of assistance to medical education most directly through operation of and with direct financial assistance to medical schools within their borders. Likewise, the federal government has an important role in continuing to target resources to specific problem areas in medical education, particularly assistance to medical students in financial need so that the medical profession is not closed to all but the wealthy.

UNDERGRADUATE MEDICAL EDUCATION

Institutional Support

The Administration has proposed elimination of all institutional support for undergraduate medical education.

The AMA encourages continued limited support by the federal government for medical schools. We believe that federal assistance can be a valuable adjunct to other resources in three major areas: assistance for reconstruction and rehabilitation of out-dated facilities; special project assistance; and assistance for institutions in extreme financial distress.

Rehabilitation and Renovation--Some medical school basic science and research facilities are out-dated and in various states of disrepair. In some cases, the facilities can pose safety hazards or are not physically adequate to be used for new equipment or laboratories. With the explosion of new technology and instrumentation, it is critical that medical schools expose their students and residents to the medical state-of-the-art since these are the people who will use these technologies after completion of their training. With inadequate or antiquated facilities, this is not always possible. Furthermore, it

would be penny wise and pound foolish to let the enormous investment we have made decay from neglect. Therefore, we support continued federal assistance for rehabilitation and renovation of medical school facilities.

Special Projects--Another area where federal support can provide necessary assistance is the support of special projects within medical schools. Such aid supports innovations in medical education that, once demonstrated, can be used in other institutions as appropriate and also can be used to address current concerns in health care delivery. Authority for such special project assistance should be broad enough to encourage the development of projects that meet unique and innovative needs. Therefore, we support continued special project assistance authority that would allow federal encouragement for new and important changes in medical education and patient care.

Financial Distress--While the AMA generally supports the utilization of local resources and market forces to determine the fiscal viability of medical schools, there are certain situations where we believe direct general financial assistance is appropriate to allow an institution to achieve financial stability. Therefore, we support financial distress grants--for a very limited period of time--for those institutions that have unique attributes or resources. Such assistance should be used sparingly and only when the institution has certain unique attributes of national significance that would be lost if a temporary financial bridge was not provided to sustain an institution through a financial crisis.

Student Assistance

Loan, Loan Guarantee and Grant Programs

The Administration's fiscal year 1986 budget proposes significant reductions in federal support for loan, loan guarantee, and grant

programs for undergraduate medical education. The Administration is proposing to limit the aggregate amount of new loans guaranteed under the Health Education Assistance Loan (HEAL) program to \$100 million in fiscal year 1986. In fiscal year 1984, the government guaranteed \$250 million of HEAL loans. In addition, the Administration's budget proposes to restrict eligibility for loans under the Guaranteed Student Loan (GSL) program to students from families whose adjusted gross income does not exceed \$32,500. It also proposes to restrict the total amount a student can receive for loans and grants under Title IV of the Higher Education Act to \$4,000 per year. The current ceiling is \$11,000. Finally, the Administration is proposing no funds for the Health Professions Student Loans (HPSL) program and for the Exceptional Financial Need Scholarship program.

Mr. Chairman, the cost of a medical education today is very high. The expenses that an individual incurs can be overwhelming to all but the wealthy. While we recognize that medical school tuitions vary, tuition can cost as much as \$75,000 over a four-year period. That amount does not include ancillary costs and living expenses and costs incurred in obtaining an undergraduate degree. Moreover, it is likely that the cost of a medical education will continue to rise in coming years as medical schools' expenses increase.

The AMA believes strongly that access to a medical education must be available to qualified persons from all socioeconomic backgrounds. Society as a whole benefits from a diversity of economic as well as cultural and ethnic backgrounds represented in the medical profession.

The AMA is concerned that the Administration's proposals could have

the effect of placing medical education beyond the financial wherewithal of students from low and middle income families. Currently, GSL loans are the primary source of financial aid for medical students. During the 1982-83 academic year, more than half of medical students relied on GSL funds and these funds provided over 40% of all financial aid to medical students. If Congress enacts the Administration's proposal to restrict GSL funds, along with its proposals to reduce the aggregate amount of new HEAL loans and provide no funds for the HPSL and exceptional financial need grant programs, the opportunity to pursue a medical education will be put out of the reach of many students from low income and middle class families.

The AMA vigorously opposes the Administration's proposed cuts in student assistance. We strongly support the availability of adequate financial assistance to students in order to ensure that access to a medical education is not limited to the wealthy. We believe that further study of the impact of any significant cuts in funding should be undertaken prior to Congressional action.

Mr. Chairman, the AMA would like at this time to state its firm position that medical students who borrow money to finance their education have both a moral and a legal obligation to fully pay their debts. The number of medical students who default on their obligations, however, is relatively small. Nonetheless, the AMA will increase its efforts to encourage all students to repay their obligations.

We believe strongly that the federal government and other lenders should take aggressive action in collecting past due obligations.

Through such collections, coupled with funds paid back in the normal course of the loan programs, funds become available to assist other deserving individuals.

The AMA Education and Research Foundation Loan Guarantee Program loaned millions of dollars to medical students and had no hesitancy in filing suit in appropriate cases to collect past due loans.

National Health Service Corps Scholarships

The Administration also proposes no funds in its fiscal year 1986 budget for National Health Service Corps (NHSC) scholarships. The Administration has determined that sufficient funds are available to continue funding the scholarships for the relatively few persons still in the NHSC pipeline.

The AMA does not believe that it is either necessary or appropriate to provide for new NHSC scholarships for the purpose of obligating service. Such a system is a very expensive way to meet manpower needs in select areas and involves extremely long lead times. One of the major problems now facing the NHSC program is the availability of too many physicians with service payback requirements compared to limited resources to fund the field strength necessary to absorb all obligated physicians. Where there may be future manpower requirements for shortage areas, we would suggest that emphasis be placed on the use of loan forgiveness rather than on scholarship programs. (We believe, however, that adequate funds should be available to continue funding the scholarships for those now in the NHSC pipeline.)

Mr. Chairman, Dr. Riddick will now present the AMA's testimony concerning graduate medical education.

STATEMENT OF FRANK A. RIDDICK, JR., M.D.

GRADUATE MEDICAL EDUCATION

Mr. Chairman, the education and training of physicians is a long and arduous process requiring years of classroom work with increasing exposure of students and physicians-in-training to the practical aspects of patient care. The first two years of education in medical school focus generally on the basic medical sciences in classroom and laboratory experiences. In the last two years as students study clinical sciences, there is increasing integration of the student into the patient-care team at the bedside.

After graduation from medical school, intensive participation in patient care begins in the form of graduate medical education. Graduate medical education, commonly referred to as residency training, places the physician-in-training in a learning and service environment in which he or she cares for patients under the supervision of licensed physicians/teachers. The resident participates in the diagnosis and management of large numbers of patients who present a wide spectrum of disease conditions. The training program is designed to offer the resident increasing levels of responsibility to prepare for the independent practice of medicine. In this way the resident acquires the requisite knowledge and skills of his or her chosen specialty.

It is through the provision of patient care in a teaching environment that a physician learns the practice of clinical medicine. It is difficult if not impossible to separate the learning and service components of graduate medical education. "Hands on" experience is absolutely necessary.

Mr. Chairman, the existing system of financing graduate medical education and training is complex. Changes must be carefully evaluated and considered since an ill-advised change could threaten the nation's ability to train qualified physicians in sufficient numbers to meet the health needs of our nation in the future. Until an appropriate alternative is developed, the AMA strongly supports the current system for financing the majority of graduate medical education costs through patient care revenues from third party payors including Medicare.

A key benefit of the existing system is the stable financial environment it has fostered. This predictable financial environment, in which teaching hospitals are assured that payment will be made for reasonable direct and indirect medical education costs, has been a major reason for the number of high quality teaching programs available. We are concerned about proposals to restructure or dramatically reduce the funding of graduate medical education because no stable alternative funding sources have been identified. Without adequate and predictable financial support, teaching hospitals would be forced to choose between two undesirable alternatives: eliminate essential teaching programs that are an integral part of the system that provides care to the sick or face large revenue shortfalls.

Teaching hospitals and their residency programs provide a number of significant benefits to the general public. Certainly, all of society benefits from having an adequate supply of highly trained physicians in all medical specialties. In addition, teaching hospitals generally have more special care units to treat burns or heart attack than do

non-teaching hospitals. As a result, teaching hospitals often serve a unique role as a medical referral center for an area offering intensive and specialized care unavailable elsewhere in a community. Finally, residents under the supervision of attending physicians provide quality patient care. In the absence of residents, hospitals would be forced to utilize more practicing physicians thereby increasing the cost of physician services.

The present system recognizes that legitimate reasons exist for higher patient costs at teaching hospitals. Teaching hospitals generally treat more complex and severe cases, provide more technologically intensive care, and provide more uncompensated or insufficiently compensated care to low-income and indigent patients. In addition, because teaching hospitals usually contain many special care units, overall occupancy rates may be lower than those of non-teaching hospitals where beds may be available for general admission. Finally, residents place significant demands on the resources of teaching hospitals that are not found in community hospitals without teaching programs.

Direct Federal Assistance

The federal government provides direct financial assistance to selected residency programs. This direct assistance, through grants under Title VII of the Public Health Service Act, supports residency training in the areas of family medicine, general internal medicine and general pediatrics.

The AMA supports continued federal assistance for these residency programs. These programs were initiated by Congress to place greater

emphasis on training in these primary care specialties. With the widespread belief that the number of primary care physicians should be increased, it would be inappropriate to eliminate funding for these residency programs. Moreover, abrupt withdrawal of support for present programs could be highly disruptive and impede development of manpower in the primary care areas of practice.

Administration's Budget Proposals Concerning Graduate Medical Education Under Medicare

The Administration's fiscal year 1986 budget proposes to reduce Medicare reimbursement for teaching hospitals' direct medical education costs to the levels that prevailed during hospital accounting periods ending in calendar year 1984. The President's budget also would cut indirect medical education payments by 50%.

The AMA opposes the reductions in graduate medical education funding proposed in the President's budget. We are particularly concerned over the proposed 50% cut in indirect medical education costs. Many inner-city teaching hospitals that provide substantial amounts of care to the poor would be severely affected. We also believe it is premature to alter hospital reimbursement until sufficient data is available concerning the impact on hospitals of the recently implemented prospective payment system. This is particularly true in light of a fundamental flaw in the DRG system -- the failure to reflect severity of illness and case-mix differentials.

The AMA believes strongly that an indepth study of the financing of graduate medical education should be undertaken before Congress considers

major alternatives. To this end, the AMA has established an Ad Hoc Committee which will conduct a thorough study of the financing of graduate medical education.

Proposals to Condition Medicare Funding of Graduate Medical Education

Mr. Chairman, proposals have been advanced concerning the use of the Medicare program as a primary vehicle for developing and implementing national health manpower policy. The AMA is very concerned over the use of the Medicare program to fashion manpower policies which affect the entire health care delivery and medical education systems. Specifically, the AMA is very concerned about conditioning Medicare funding of graduate medical education to a requirement that the majority of residency positions offered by a hospital or group of hospitals at any one time must be in the primary care specialties. Such a requirement could be too rigid for a hospital or group of hospitals to achieve. For example, some teaching hospitals may find it extremely difficult to establish or expand pediatrics or obstetrics/gynecology residencies because of an insufficient number of patients to run a high quality program and meet standards of accreditation as established by the Accreditation Committee on Graduate Medical Education. Other factors which could hamper a teaching hospital's ability to increase its proportion of residency positions in the primary care specialties include a lack of necessary faculty or physical facilities. Because of the serious effects on teaching institutions, any requirement for substantial increases in primary care positions would need an extended period of time for implementation.

Conclusion

The U.S. medical education system, both graduate and undergraduate, is the benchmark against which other medical education systems in the world are judged. Preeminence in medical education has been achieved by virtue of strong financial support from federal and other sources as well as the dedication of medical schools and teaching hospitals to quality medical education.

The AMA believes strongly that qualified persons regardless of their economic background should be afforded the opportunity to pursue a career in medicine. In order to ensure that medicine does not become the province of the wealthy, we believe that the Administration's proposals concerning the HEAL, GSL, HPSL, and Exceptional Financial Need Scholarship programs should be rejected.

In addition, we are extremely concerned over proposals for significantly changing the existing system of financing graduate medical education before satisfactory alternative sources of funding are identified. The system of financing graduate medical education is complex and changes must be carefully considered. In fact, the impact of recent changes in the funding of hospital care under Medicare on residency programs cannot be determined at this time. Precipitous action could undermine not only our graduate medical education system but the quality of our health care system as a whole.

We urge Congress to continue its long-standing commitment to quality graduate medical education and ensure that the Medicare program continues to pay its fair share of the costs of a system that benefits Medicare beneficiaries and the nation as a whole.

Mr. Chairman, thank you for providing us with this opportunity to testify. Dr. Deal and I will be happy to answer any questions Members of the Committee may have.

APPENDIX
HISTORY OF FINANCING
GRADUATE MEDICAL EDUCATION

Payment for GME Under Cost-Based Reimbursement

From the inception of the Medicare program, teaching hospitals have been reimbursed on a "reasonable cost" basis for their direct medical education costs. Direct medical education costs are expenses directly related to a hospital's teaching activity. These costs include the salaries and fringe benefits of residents and the portion of teaching physicians' salaries that is attributable to educational activities.

For many years, teaching hospitals received no special payment for expenses indirectly related to the teaching of residents. Instead, provisions for reimbursement of ancillary services and the "cost-based" reimbursement system covered these costs. Then in order to prevent a disproportionate number of teaching hospitals from being adversely affected by the existing Medicare limits on reimbursement of routine hospital operating costs, HHS in 1980 modified the limits to include a resident-to-bed adjustment for the indirect costs of graduate medical education. These costs reflect the increased demands that residents place on other hospital staff and the tendency of residents to provide more services and conduct more tests. Indirect medical education costs are also used to reflect case-mix intensity. The indirect medical education adjustment was set initially at 4.7% for each 0.1 full-time equivalent (FTE) resident per bed. The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) replaced the routine cost limits with limits that covered total inpatient operating costs thereby including special care unit costs under the limits. As a result, for hospital cost reporting periods beginning on October 1, 1982, the resident-to-bed adjustment was increased from 4.7% to 6.06% for each 0.1 FTE resident per bed.

Payment Under The Prospective Payment System

The Prospective Payment System (PPS), established under Title VI of the Social Security Amendments of 1983 (P.L. 98-21), retained special treatment of direct and indirect medical education costs.

Direct Medical Education Costs Under PPS

In its 1982 report to Congress entitled Hospital Prospective Payment for Medicare, HHS advocated a continuation of cost-based reimbursement for direct medical education costs. The report stated:

The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital. This approach will allow for continued Federal support of medical education through the Medicare program while clearly identifying that support as separate from patient care.¹

Congress agreed that the direct costs of medical education should not be included in the diagnosis-related group (DRG) payment. Thus under PPS, teaching hospitals are reimbursed for their direct medical education expenses on a reasonable-cost basis in addition to the DRG-based per case payment. Medicare's portion of a hospital's direct medical education costs is calculated based on generally accepted accounting principles and includes, in addition to salaries and fringe benefits, allocated overhead expenses such as administration, maintenance, and utilities.

Indirect Medical Education Costs Under PPS

The HHS report also proposed an adjustment in DRG payment rates based on the ratio of residents-to-beds in teaching hospitals. The report stated:

The indirect costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs. Although it is not known precisely what part of these higher costs are due to teaching (more tests, more procedures, etc.), and what part is due to other factors (the particular types of patients which a teaching hospital may attract), the Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals.

It is also clear that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education results in very intensive treatment regimens. Again, the relative importance of the various reasons for the higher costs observed in teaching hospitals is difficult to identify precisely. However, there is no question that hospitals with teaching programs have higher patient care costs than hospitals without.

¹ U.S. Department of Health and Human Services. Hospital Prospective Payment for Medicare December 1982 PP. 47-48

The Department believes that recognition of these indirect costs should be accomplished through a lump-sum payment, separate and distinct from the base rate. This adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total cost limits for the indirect costs of graduate medical education. The hospital's cash flow will be preserved by some sort of periodic payment.²

Congress also concurred with this recommendation and, because of analyses showing that teaching hospitals would suffer greater financial losses than non-teaching hospitals under the DRG system, P.L. 98-21 doubled the existing educational adjustment factor. In reporting the legislation, the Senate Finance Committee acknowledged that an additional payment to teaching hospitals for indirect medical education expenses is appropriate

. . . in the light of serious doubts (explicitly acknowledged by the Secretary in his recent report to the Congress on prospective payment) about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents.

The latter costs are understood to include the additional tests and procedures ordered by residents as well as the extra demands placed on other staff as they participate in the education process. The committee emphasizes its view that these indirect teaching expenses are not to be subjected to the same standards of "efficiency" implied under the DRG prospective system, but rather that they are legitimate expenses involved in the post graduate medical education of physicians which the Medicare program has historically recognized as worthy of support under the reimbursement system. (Emphasis added)

Under PPS the indirect medical education adjustment provides an 11.59% increase in the DRG portion of the prospective payment rate for each 0.1 FTE resident per bed. Medicare regulations define the number of a hospital's FTE residents to be the sum of the number of residents employed at least 35 hours per week, plus one-half of the number of residents who work less than 35 hours per week. The recently enacted Deficit Reduction Act (P.L. 98-369) included an amendment that permits teaching hospitals to count all residents who provide services in the hospital, regardless of whether they are employees of the hospital.

² Id. at 48-49

Mr. WAXMAN. Thank you.
We will now hear from Mr. Marylander.

STATEMENT OF STUART J. MARYLANDER

Mr. MARYLANDER. I am Stuart J. Marylander, the president of the Cedars-Sinai Medical Center in Los Angeles and Chairman of the AHA Special Task Force on Financing Graduate Medical Education.

I want to thank you for your generous comments about me personally and to say that we consider ourselves as extremely privileged to have you as our representative.

You have our written testimony, and I would like to take just a few minutes to review what I consider to be the critical points.

First I would like to comment that medical education is not separate and distinct from patient care. The medical education process is a patient care process, and any erosion of the medical education process will be an erosion of the patient care process.

In this we know that the tertiary capability of the teaching hospital is due in large measure to the presence of graduate medical education programs and all that are associated with them. Teaching hospitals provide the foundation which enables the current health care system to function by caring for those patients which require its unique services while at the same time making major contributions to the care of the indigent, the support of medical research, and to the maintenance of an appropriate health manpower supply.

Therefore, any decrease in the financing of graduate medical education will threaten the very existence of this fragile and uniquely valuable national health care resource.

Current congressional interest in dealing with the financing of graduate medical education through adjustments to the prospective payment system is of grave concern to the AHA because of the fact that the DRG system, as Dr. Riddick pointed out, is flawed. These flaws include the fact that it was based on judgments which require constant adjustment and refinement, as experience dictates, as we learn from use of the system.

Second, it is based on averages that existed prior to current improved utilization management and other UR activities. These activities have eliminated many of the less expensive cases designed to offset the more expensive cases cared for in hospitals.

Third, the system does not provide or adequately provide or account in variations of severity of illness of patients treated in the Nation's teaching hospitals. As Dr. Heyssel pointed out, it is imperative that we not arbitrarily decrease the payment for the indirect cost of graduate medical education as they were intended to pay for items such as the differences in severity of illness, differences in case mix, costs incurred in the care of indigent patients not otherwise provided, and the like.

At this point, I want to comment. There has been a great deal of effort placed on the fact that caring for the indigent contributes significantly to the severity of illness in teaching hospitals. Most all of the patients who are seen in teaching hospitals today suffer a higher severity of illness than do patients seen in nonteaching hos-

pitals, and the severity of illness issue should not be looked upon as only a function of indigent care but of all the patients who are cared for in the Nation's teaching hospitals.

Similarly, we feel that the direct costs of graduate medical education should not be treated any more harshly than any other direct cost of care under PPS. It is critical to be aware of the fact that the migration to the natural average impacts disproportionately on the Nation's teaching hospitals, and seriously compromises things.

In our opinion, these flaws must be addressed satisfactorily before dealing with the financing of graduate medical education if untoward consequences to the Nation's teaching hospitals are to be avoided.

Other proposals have attempted to deal with graduate medical education in a fragmented fashion. We believe it is critical for Congress to be aware of the fact that medical education is a continuum which starts with medical school, where the student is prepared academically for graduate medical education, and continues through the graduate process where the student is actually prepared to practice medicine.

It follows, therefore, that we should not use the financing of graduate medical education to deal with the issues of manpower policy, specifically the issues of numbers of physicians, specialty mix, and geographic distribution.

In addition, it is important to be aware that by limiting the financing of graduate medical education to certain primary care specialties or capping the number of years of support, the potential may exist where only the wealthy will have access to training for certain specialties.

The issue of medical school affiliation has also been raised as a mechanism for controlling the composition of residency programs. In this regard, it is important to note that although 98 percent of the teaching hospitals have medical school affiliation, mandatory affiliation and control over residencies by medical schools would not ensure the desired outcomes.

Many of our outstanding teaching hospitals with medical school affiliations operate independently approved residency programs of superior quality, and these programs could be placed in jeopardy through such a proposal.

In addition, as we previously noted, without graduate medical education, the ability of many institutions to provide for special groups of patients such as the indigent group will be severely compromised.

Similarly, the environment that permits most of today's medical research would also be placed at risk, if not eliminated.

In closing, I would like to say that we fully recognize the fact that marketplace competition is now becoming a force in the health care arena. We are likewise quite cognizant of the need for a mechanism for the financing of graduate medical education that enables the teaching hospitals to otherwise compete in this new environment.

At the same time, we are keenly aware of the fact that we must not allow this urgent need to lead us into immediate short-term so-

lutions without the most careful examination of the long-term impact on the patient care rendered the American public.

To fail to do so may well result in the most undesired of outcomes.

Thank you very much.

[Testimony resumes on p. 305.]

[The prepared statement of Mr. Marylander follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
OF THE HOUSE COMMITTEE ON ENERGY AND COMMERCE
ON FINANCING GRADUATE MEDICAL EDUCATION

April 3, 1985

SUMMARY

The hospital industry is in a state of ferment. Recent changes in Medicare policies such as the adoption of a prospective pricing system (PPS) and the piecemeal implementation of the Peer Review Organization (PRO) program, while creating many positive incentives, have also made uncertainty the central characteristic of the hospital environment. Early data suggest that hospitals are responding positively to the implementation of the PPS system. However, as the movement toward national rates continues, many hospitals may experience significant financial losses. In some hospitals, these losses will reflect the inability of the diagnosis-related group (DRG) system to account adequately for the severity of illness of patients treated in teaching and referral centers. Since many of these hospitals are involved in medical education, changes in Medicare's medical education payment policies should be postponed until the impact of PPS on referral hospitals is better understood.

Medical education is not separate and distinct from patient care. Interns and residents receive an education as well as provide patient care during their residencies. The involvement of an institution in medical education also can have a positive effect on quality of care by encouraging peer review, providing educational opportunities for attending staff, and attracting highly qualified physicians to the hospital's medical staff. Similarly, the types of patient care provided by a hospital have an impact on the quality of the educational experience available to interns and residents.

Consequently, changes in the method of payment for medical education will lead to changes in patient care, and changes in payment for patient care may alter the ability of hospitals to provide an adequate educational experience. However, the complex relationship between patient services and medical education is not easily defined, reflecting the fact that medical education is both a product and a resource. Current Medicare accounting methods do not permit a precise allocation of education costs between education, per se, and patient care. Until the role of medical education in patient care is more precisely identified, changes in payment methods should only be studied, not adopted.

INTRODUCTION

Mr. Chairman, I am Stuart J. Marylander, president of Cedars-Sinai Medical Center, a 943-bed teaching hospital in Los Angeles. I am pleased to be here today on behalf of the American Hospital Association to present its views on the issue of financing graduate medical education.

At the outset, I would like to point out to the Subcommittee that the AHA is currently working to develop its formal position on this very important issue. A Study Group on Financing Graduate Medical Education, which I chair, has been formed and held its second meeting last week. This group is charged with examining the current system of payment for graduate medical education and a variety of proposals for modification and change. The AHA will be pleased to share with the Subcommittee the results of this study group's deliberations when they are complete, but today I would like to offer some preliminary comments and concerns on the issue of graduate medical education.

Last fall, Senator Durenberger held hearings on a proposal to create within Medicare a block grant program, operating through the states, to pay for Medicare's share of direct graduate medical education costs. The AHA opposed

that proposal, both because it would involve state government inappropriately in the administration of Medicare, and because it does not recognize the complex relationship between medical education and patient services.

AHA continues to oppose changes in Medicare's method of payment for medical education until the implications of current payment policies for teaching and referral hospitals are better understood. Immediate change is not necessary. While the long-term outlook of the Medicare program continues to be troublesome, an immediate crisis has been averted, largely because of the strong, positive response by hospitals to the incentives of PPS and the continuing strong performance of the economy. The 1985 report of the trustees of the Medicare Trust Fund, just released, shows that projected growth in hospital costs is substantially lower than previously estimated, resulting in lower Medicare outlays for the foreseeable future.

- The trustees assumed "input prices" would rise by 5.9 percent during calendar year 1984; the actual increase was 5.7 percent.
- The trustees assumed admissions would increase by 2.0 percent during calendar year 1984; admissions actually declined by 2.9 percent during the year.
- The trustees assumed hospital employment would continue to increase more rapidly than employment in other sectors of the economy; hospital employment actually declined during 1984.

Statistics clearly indicate that hospitals have responded rapidly and positively to the new environment, despite considerable uncertainty. Most important, the response has not been limited to Medicare. Total hospital expenses for the past year have increased by only 4.5 percent, while inpatient expenses increased by only 3.2 percent. Given this strong performance, there is time to assess carefully the options for further reform. Such assessment is critical because the longer-term effects of implementing PPS are still unknown. If the movement toward national rates is based on a mistaken assumption that DRGs accurately reflect the types of patients admitted to hospitals, the transition to national rates could have a detrimental effect on hospitals providing advanced, tertiary services, and many of these hospitals are the ones involved in medical education. It is, therefore, essential to explore modifications to the current payment system, such as DRG-specific price blending, that will reduce the potential for these undesirable effects.

TEACHING HOSPITALS AND THE PAYMENT SYSTEM

The prospective pricing policy enacted by Congress is intended to reduce differences in the amount paid for similar services provided in different hospitals. PPS represents a major change in hospital payment, and the long-term effects of this change are as yet unknown. The Congressional Budget Office's preliminary analysis of the impact of prospective pricing suggests that teaching hospitals, particularly those without exceptionally large teaching programs, are especially vulnerable to revenue losses as the system moves toward national rates. The system of DRGs is still largely untested,

and evidence is accumulating that differences in case mix beyond those picked up by DRGs have a legitimate effect on hospital costs. The development of an appropriate policy is further complicated by the absence of data on both the costs of medical education and the contribution of medical education to patient care.

To compensate partially for the limitations of DRGs in this area, Congress included a special "indirect" medical education factor. We believe this factor is misnamed, because it combines the effect of education on costs with the effects of treating a more complex and costly case mix. Medicare cost-finding techniques, as well as the statistical techniques used by the Health Care Financing Administration (HCFA), cannot clearly identify the cost of education. In fact, it probably is impossible to separate the costs of education from the costs of patient care because the two activities are interdependent. Education programs increase the ability of hospitals to offer certain specialized services by attracting qualified physicians and by ensuring physician coverage for patients with severe or complex illnesses. Similarly, it is the tertiary services that make teaching hospitals suitable sites for medical education. Reducing support for medical education will inevitably have an impact on the ability of hospitals to continue their medical education programs, but also on the ability of teaching hospitals to continue providing tertiary services.

The Administration's proposal to cut the indirect medical education factor by 50 percent increase the vulnerability of teaching hospitals. Such an action,

while being proposed as part of a budget "freeze," actually would reduce the revenues of all teaching hospitals, causing severe financial hardship for many referral centers. It is important to recognize that, under the Medicare PPS, the total revenue available to the hospital to support its operations is constrained, even though a distinction is made between operating costs -- which are to be covered by the DRG-based price -- and the "non"-operating costs, such as medical education and capital. If a DRG price, including the allowance for the so-called indirect costs of medical education, does not cover the hospital's operating costs, the hospital will have to eliminate some of the resources it currently employs. As these cutbacks occur, the ability of the hospital to continue its commitment to medical education may be seriously eroded. Similarly, reductions in funding for medical education will necessitate cutbacks in education programs. As education programs are cut back, it may be increasingly difficult to continue providing the range or level of tertiary services offered by the hospital, particularly in those areas where housestaff are an integral part of patient care.

Teaching hospitals occupy a critical position in the nation's hospital system. While HCFA has not released specific data, it is believed that teaching hospitals provide a disproportionate amount of care for "outlier" patients--patients whose lengths of stay exceed the average for their DRGs--suggesting that the patients seen in teaching hospitals are, on average, more seriously ill than the patients seen in non-teaching hospitals. While the Medicare payment system does provide additional payments for outlier patients, these additional payments cover only the portion of the patient's

stay designated as the outlier days or costs. It does not recognize the higher average costs that will be experienced by a hospital treating a disproportionate number of outlier cases.

A simple, hypothetical example illustrates the problem. Hospitals A and B are located in the same community and are paid the same "standardized" price of \$3,000 per case. Hospital A admits no outlier patients, and incurs costs of \$3,000 per case. In contrast, 10 percent of Hospital B's patients are outliers. The average cost-per-case of the non-outlier patients admitted to hospital B is also \$3,000, but the average cost of outlier patients is \$14,000. The additional payment for outlier patients is limited to 60 percent of the amount in excess of \$13,000, or \$600. Hospital B is, consequently, paid \$3,060 per case, despite the fact that its costs are \$4,100 per case, resulting in a loss of \$1,040 per case even though it is as efficient as hospital A in providing care for non-outlier patients. It should be recognized that hospital B will incur a loss, no matter how "efficient" it becomes, as long as it continues to treat outlier patients.

Teaching hospitals also provide much of the referral or tertiary care needed by the Medicare population. The role of teaching hospitals as referral centers is not restricted to those hospitals directly associated with medical schools. Smaller teaching hospitals, and teaching hospitals involved primarily in graduate medical education, also are important sources of tertiary services in their communities. Efforts to reform payment for medical education costs must recognize that the current "indirect" payment has been

characterized as a proxy for a severity index, and that treatment of the more seriously ill patients means provision of referral services. Therefore, involvement in medical education, and not simply medical school affiliation, is the appropriate indicator of referral status.

Changes in the method of payment for medical education are likely to disrupt, rather than rationalize, the delivery system. Hospitals are still uncertain about their future financial viability under PPS, particularly as Congress continues to tinker with the pricing formula in an effort to produce short-term budget savings. Changes in the pricing system should be considered, but only when they are needed to correct fundamental flaws in the design of PPS or in the data upon which that system was based. DRG-specific price blending is such a proposal, as is the institution of adjustments for the higher costs experienced by hospitals treating a disproportionate number of low-income patients, or efforts to correct the inaccuracies of the Bureau of Labor Statistics data on which the area wage index is based, or efforts to develop more realistic definitions of hospital labor markets. All of these problems can create significant inequities. Before the expansion of PPS is considered, and before a new method of handling the cost of medical education is adopted, the effects of the changes that already have been made must be determined. It is more important for the immediate future to deal with the issues created by the adoption of PPS, and the inequities that have resulted, than to move on to new areas. Only after these issues are resolved, should Congress address issues such as the reform of medical education.

Numerous proposals for modifying the current system of financing graduate medical education have been offered. In some, Medicare and other payers would fund only one year or only three years of training after medical school. If such arbitrary limits on funding are set, many services provided by interns and residents, who are practicing physicians, will likely be billed under Medicare Part B. Perceived savings by reducing Medicare Part A expenditures would be, therefore, illusory.

Other proposals raise the issue of the appropriate role that Medicare should play in the development of national manpower policy. While Medicare, along with other third-party payers, will have a significant role in implementing manpower policy, the formulation of that policy should be located outside the program. Responsibility for establishing education policy should involve groups other than third-party payers, including representatives of accrediting bodies, hospitals providing medical education, medical schools, and the public. In determining the appropriate number and specialty mix of physicians to be trained, market factors and community needs should be among the foremost considerations. The number of training slots offered by a hospital, as well as the level of stipends, depends on a wide number of factors, such as the availability of faculty and the case mix of the hospital, and is best determined by the hospital, the accrediting bodies, and, where applicable, medical schools. Relying on the Medicare program to set or enforce federal guidelines on training programs could lead to a formulaistic approach that is not responsive to local needs and capabilities.

Finally, some questions have been raised about the effectiveness of the current accrediting program operated by the Accreditation Council for Graduate Medical Education (ACGME) in exercising control over the quality of graduate medical education programs, and about the advisability of requiring teaching hospitals to have affiliation agreements with medical schools. AHA believes that the ACGME, which sets minimum requirements for the quality of programs, is working well, and that the responsibility for evaluating the quality of such programs should remain with the private sector. Further, although the ACGME does not require affiliation, 98 percent of all teaching hospitals, in fact, have some sort of affiliation agreement with a medical school. However, it is important to keep in mind that some of the nation's leading teaching hospitals are not the primary affiliates of medical schools.

Changes in Medicare's payment policies for medical education will have serious consequences for national manpower policy and the content of graduate medical education, as well as patient care. Such reforms cannot be based simply on the desire to save money. The movement toward competitively oriented payment systems in both the public and private sectors is demonstrating the superiority of market forces as a means of containing the costs of medical care. However, competitive payment mechanisms are highlighting the more difficult health policy issues, such as financing medical care for the medically indigent and financing medical education. Fundamental reforms probably will be required to address these issues. Such reforms will take time to develop, particularly as the environment in which they will operate is

still rapidly evolving. The type of financing mechanism for medical education that will be appropriate in the new environment cannot be determined until the pace of change slows.

CONCLUSION

The issue of medical education is enormously complex, involving decisions affecting every aspect of the health care system. The future of medical education is affected by both the policies overtly addressing education and the policies affecting patient care. At the same time, policies affecting medical education have implications for patient care. An appropriate policy can emerge only from a full and intensive debate of these important issues, combined with a more complete understanding of cost and process of medical education, the relationship between education and patient care, and the implications of the financing environment for hospitals involved in medical education. The enormous changes that have occurred in the past several years have created a great uncertainty about the ability of teaching hospitals to continue providing the types of services they have. Until this uncertainty is reduced, we should proceed cautiously.

Mr. WAXMAN. Thank you very much, Mr. Marylander, Dr. Deal and Dr. Riddick.

Dr. Deal and Dr. Riddick, let me start with you.

In your view, do we have a serious problem looming ahead on the surplus of physicians and do we have a serious problem of specialty and geographical distributions? Are these concerns legitimate concerns?

Dr. RIDDICK. I think they are legitimate concerns. I am not sure we have a consensus on what the answer is. The AMA has a position that a reasonable target would be to have at least half of the medical school graduates enter primary care fields.

We are doing that right now. About 60 percent of those graduates enter primary care fields. We do not have an accurate measure on whether they stay in those fields for the remainder of their career, and actually, tracking physician activities indicates the number of primary care physicians probably is not increasing.

You have to counterbalance that by the fact that primary care services are provided by a number of specialists, so we don't have the data. We are not far off of what was assumed to be a reasonable starting point a number of years ago.

With respect to the question of number of physicians, you have heard earlier that guesses of a possible surplus vary by 100 percent based on different techniques. There is no question we have more physicians than we used to have. We are going to have more in the future. Whether that is an absolute excess or not, whether these physicians cannot be employed gainfully in providing medical services and improving the health of the nation is something I think we have to look at.

We haven't got a position on that. Dr. Deal is an expert on GMENAC. I will ask him to comment.

Dr. DEAL. Mr. Chairman, I agree with what Dr. Riddick said. I think we have several things that we really don't know what our surplus is going to be, in my opinion, simply because of two factors which I don't believe GMENAC really included. That is, we have an increasing number, approximately one-third, of young people in medical training today are women. We are delighted with that.

It also did not take into consideration that, for the very, very good reasons that these women are in medicine, historically they have not practiced as many hours per week as the male counterpart, for very good reasons. We don't know where that impact is going to be, and I think the pipeline is just now beginning to fill up.

We do know from medical school standpoints that young men and women are finding 40- to 45-hour workweeks very attractive, in contrast to 60 to 80 as many of us grew up in. So we really don't know, in a nutshell.

Mr. WAXMAN. As we look at, say, the specialty distribution, I don't think any of us would want to see any kind of regulatory approach. Do you think we can use these financing mechanisms to shape some incentives for people to make choices that would be more consistent with the broader public policy?

Dr. DEAL. I think, Mr. Chairman, that is possible. I think if you look at the original Health Manpower Act back in the sixties, cer-

tainly that was an incentive for medical schools to virtually double their enrollment. That did occur.

Mr. WAXMAN. We succeeded.

Dr. DEAL. You certainly did.

Mr. WAXMAN. Beyond, perhaps, our wildest dreams.

But we succeeded in more physicians being produced, but have we succeeded in the distribution between specialties?

Dr. DEAL. I think we are seeing better distribution through the self-selection process of the young people entering postgraduate training. As Dr. Riddick said, this past year, in the recent past, 64 percent of medical school graduates as of June 1985 were under a primary care discipline, at least for their first postgraduate year, and what they will be doing 4 years from now, we really haven't been able to track; but I think there is an increase in interest and concern of young people to go into primary care.

Mr. WAXMAN. The AMA has an Ad Hoc Committee on Financing Graduate Medical Education. I assume we are going to have some recommendations from that ad hoc committee. Do you have any timetable for that?

Dr. DEAL. Dr. Riddick is chairman of that committee.

Dr. RIDDICK. We would hope to have something by the end of this calendar year, but we are early in the stages.

Mr. WAXMAN. In the meanwhile, your recommendation to us is not to make changes in the way we deal with graduate medical education.

Dr. RIDDICK. Yes, sir.

Mr. WAXMAN. Mr. Marylander, your recommendations are quite similar. You are suggesting that we ought to keep where we are until we get more information. I think the AHA has a study group, as well; is that true?

Mr. MARYLANDER. That is correct.

Mr. WAXMAN. And I would guess it is particularly important to those of you involved in the day-to-day operation of a teaching hospital that we not make these changes every year so abruptly that you then try to keep on top of it and make decisions that may not be the most thoughtful decisions in trying to mesh in with what you are hearing from Washington in terms of reimbursement.

Mr. MARYLANDER. That is absolutely correct, Mr. Chairman. The imposition on the hospitals to make short-term reactive adjustments based on short-term changes in the financing mechanism often creates situations that are less than desirable and require a great deal of effort and expense to reverse.

Mr. WAXMAN. The testimony we had this morning from Dr. Desmarais from HCFA was that he thought that we had given artificially too much money and we could cut it in half, and that decisions would then be made by the affected parties and they would make all the adjustments necessary to carry on all those extra, complicated matters that teaching hospitals deal with.

He felt pretty confident that you can adjust, that you just have less money but then you would have to restructure.

How would you start to address those policy changes? It is not clear to me what that means when you say you are going to make an adjustment. I am not sure they know what adjustment you are going to make. Do you have any ideas that you can tell us of ad-

justments you would have to make and others would have to make in the teaching hospital area?

Mr. MARYLANDER. Yes, sir. I think I would like to start by saying I think two issues became confused in that discussion. A great deal of emphasis was placed on making the teaching hospitals more efficient. It was through that efficiency that they were going to be able to continue to do a good job even though the indirect reimbursement would be cut in half.

I think it is important to note that the teaching hospitals, along with every other hospital in the United States where the Medicare patient is placed on the same kind of aid system, that motivates them to be just as efficient, if not more efficient, than any other institution, and that the purpose of financing graduate medical education; second, was because it was an additional cost over and above that normally required to care for the usual patients.

I think this needs to be kept in mind; otherwise, we will make, I think, some drastic judgments. The use of payment for the direct costs of graduate medical education, should it be reduced, would undoubtedly result in a direct reduction of the number of house staff that an institution could afford because in the days previous, just as the question that was asked about indigent care prior to 1965, cost shifting was a mechanism for financing those kind of activities.

That option no longer exists today, so the institution would have no choice but to reduce the number of house staff it could train, and the tragedy of that is its impact to render the kinds of services that that institution exists primarily for in its respective community.

Mr. WAXMAN. If we see the other third-party payers moving away from teaching hospitals, as we had some speculation, that would put an even greater pressure on teaching hospitals to cut back because of the squeeze on Federal funds.

Mr. MARYLANDER. Yes, we see that in the State of California right now, where competition is the name of the game in paying for health care, and there are aggressively competing forces in the environment that make it no longer possible to survive because you offer a quality program or a comprehensive program but where price becomes the predominant criteria.

Mr. WAXMAN. So all these uncertainties that are now happening in the health care delivery area are affecting hospitals and new DRG system now going through a transition, move toward third-party payers, going away from teaching hospitals, and increase in some of the proprietary hospitals taking patients away from hospitals that serve inner city areas, a whole bunch of other factors; we are moving through a time of a lot of uncertainty.

If we come in with a meat ax approach to Federal Government reimbursements saying, "Here is the amount you are going to live with," we may be doing a lot of harm.

Mr. MARYLANDER. Yes, sir. And I think it would be jeopardizing a very, as I said, fragile and unique national health resource.

Mr. WAXMAN. Thank you very much.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Dean Deal, is the University of Florida Medical School Teaching Hospital rolling in money?

Dr. DEAL. No, sir, I wouldn't put it that way. Because of improved operating efficiencies, both administrative and otherwise, we do have a slight excess of income versus expenses for the past year. But we are not, to put it in your terms, "rolling in money."

Mr. BILIRAKIS. That's a term that was used previously in testimony here today.

Would that particular school be injured greatly if the administration's proposals were put into effect?

Dr. DEAL. Yes. That is certainly our primary teaching hospital. It would be. We would have to, as Mr. Marylander said, take a hard look at the number of residency slots that we do currently offer, and we do have a large primary care program.

I think that we would have to make extra efforts and look at our patient mix. And that would be, I believe, detrimental to the quality of the Educational Program, because nonpay patients do in fact enrich our educational programs. And I think hospital management would have to look at the patient mix very carefully to make up for any loss of revenue, and I think it is possible a curtailing of some services that we are not able to provide would have to be reviewed.

Mr. BILIRAKIS. In that connection, sir, as I understand, we have 17,000 individuals graduating from American medical schools each year. There are 22,000 residency positions available each year. Apparently the additional 5,000, the difference between the 17 and the 22, are filled by foreign medical graduates. Is that correct?

Dr. DEAL. Most are, yes, sir.

Mr. BILIRAKIS. Who fills them if they don't fill those 5,000? Do some just go wanting—in other words, not filled at all?

Dr. DEAL. There are some that are unfilled. Also there are hospitals that choose not to fill a position if it is not—on Match Day, March 13, I think, this year, if those programs do not fill the overall national match, they simply don't fund those programs for the forthcoming year. That has happened recently.

Mr. BILIRAKIS. Since my son Mike turned out to be one of those foreign medical students, if he can't get in here in this country, I hesitate to ask this question, but I guess I'm going to have to:

Is there any reason why the number of residency positions should not be reduced, in view of the fact that only 17,000 of the 22,000 are filled by our own boys, so to speak, graduating from American medical schools?

Dr. DEAL. The AMA policy, which I obviously agree with, is that there should be certain training spots, certain slots that would encourage foreign aliens to come in on an exchange visa and obtain the postgraduate training at the level at which we are able to get in this country, and go back to their developing nations.

Mr. BILIRAKIS. Do they go back to their developing nations?

Dr. DEAL. Because of some changes that I think you people have made recently in the last several years in immigration laws, I think it might perhaps be too early to tell. But certainly the intent is for people to return to their homeland.

Mr. BILIRAKIS. Until recently many of them were not returning to their home countries, where they were really more needed than they are here; isn't that true?

Dr. DEAL. Yes, sir.

Mr. BILIRAKIS. Is the AMA even considering exploring their position as far as the larger number of residency positions being available?

Dr. DEAL. I am going to defer to Dr. Riddick on that.

Dr. RIDDICK. We are going to look at a lot of things when we look at financing. I think it should be made clear that the AMA's basic position is that the accreditation of educational programs, including residencies, should be on the basis of educational criteria, and not in an attempt to control numbers.

We have different mechanisms that govern the number of residencies and the number of medical students. They are not congruous. The total number of residencies offered is the result of individual decisions by the teaching hospitals and the accreditation decisions of various residencies, review committees and the ACGME.

So that it is not unusual that two different systems, one an undergraduate medical school system and one a graduate medical school system, wind up with differing numbers of positions.

As you have alluded to earlier, there is a surplus of first year positions. More are offered than we graduate. That has always been the case, going back before the number of medical school graduates had its precipitous climb; at a time when we had 6,000 or 7,000 U.S. medical graduates, there were still 10 to 12,000 first year positions offered.

Mr. BILIRAKIS. Well, you know, I certainly—and I mean this. I see much value in us helping to train graduates of foreign medical schools. I am not just talking about the Caribbean. I am talking about other countries, too, truly foreign rather than American boys and girls going to study medicine in these foreign schools. And there is some value to it. There is no question about it, we have got to be concerned about the overall world and about training some of these people, provided they are going to go back and help their people, which is what was the original intent. I feel very, very strongly about that.

But, you know, considering the fact that we are all required to tighten our belts here, and considering the fact that an additional 5,000 residency positions translates into additional costs, additional taxpayers' dollars, I would ask the question, is there something magic in 22,000 residency positions being available from the standpoint of treating indigents, treating the poor, and that sort of thing? Is it just merely that the total residency positions available in the various hospitals throughout the country have been totaled out and it turns out to be 22,000 and nothing magic at all about that figure?

Dr. RIDDICK. I think that is the case right there, and I would think that if all of a sudden one could wave a wand and shrink that number to, say, 16 or 17,000, I don't think that we would like the results. It probably would not impact significantly at all on Dr. Deal's institution or on the institutions at which I practice.

However, Congresswoman Collins indicated that in her district there is a hospital that would be bereft of residents. There are

many inner city hospitals that deal with heavy indigent loads who are highly dependent on the presence of foreign medical graduates.

Mr. BILIRAKIS. Why they are dependent on foreign medical graduates is because apparently the American graduates are choosing not to go there; isn't that correct?

Dr. RIDDICK. That is correct.

Mr. BILIRAKIS. When in fact that shouldn't be the case. We should take a part in all of that and determine, for crying out loud, that all of the needs are met. We are talking about meeting needs in rural areas and urban areas and that sort of thing. We are talking about the specialties and whatnot, and making the best form of medical care available to the American people. By gosh, it's a privilege. I don't know why anyone wants to go to medical school in this day and age, but it is certainly a privilege to be admitted into a medical school. And I think that ought to be tied in to possibly where you might take your residency, and I might hazard to say it's probably the best form of residency training, too, I would imagine, in some of these more indigent type areas.

Dr. RIDDICK. If society wishes to collectively decide to shrink that number or direct graduates into various areas, then this is probably an appropriate thing for society as a whole to do. We would just take the position at the present time a reduction in the dollars at this stage would not necessarily give the desired effect.

Mr. BILIRAKIS. Well, society is paying the bill, or at least a good portion of the bill. I suppose society may feel they should take a hand in it.

Has the HCFA, as our chairman calls them—and we do a lot of that up here in Washington—coordinated or counseled with the AMA at all before they made this decision or were a party to this decision in terms of these cuts, freezes, reductions, and whatnot?

Dr. RIDDICK. The answer is no.

Mr. BILIRAKIS. When did the AMA—

Mr. WAXMAN. If the gentleman would yield. They didn't even talk to the Public Health Services, which is part of their own administration, to decide what the manpower impact would be.

Mr. BILIRAKIS. When did the AMA decide to establish its ad hoc committee?

Dr. RIDDICK. It made the recommendation in December, and by the time—

Mr. BILIRAKIS. In December? Was that after—

Dr. RIDDICK. In December the recommendation was made, and it percolated through during the past few weeks.

Mr. BILIRAKIS. Is that after they realized the Administration was going to come up with these recommendations?

Dr. RIDDICK. That was not a factor in their original recommendation. The original recommendation was based on the fact that it is clear that many of the changes in society, including concerns over the funding of the Medicare Program, are going to have an impact on funds available for graduate medical education. And we would like to have time to at least look at all the implications so we could at least play a part and have suggestions as to how to approach this.

Mr. BILIRAKIS. Good. I am glad to hear that answer because I have always felt, frankly, that many of the professions just quite

often don't really see the real world handwriting on the wall, and wait until quite often the cow has already left the barn before they decide to get involved in things of this nature.

So I am pleased to hear your answer.

I thank you, Mr. Chairman. Thank you, Doctors.

Mr. WAXMAN. Thank you, Mr. Bilirakis.

Mr. Nielson.

Mr. NIELSON. Mr. Marylander, you have been neglected lately.

Mr. MARYLANDER. I haven't minded.

Mr. NIELSON. You made the statement teaching hospitals should be on the same basis as other hospitals as far as indirect medical adjustment is concerned. Then you said there should be some other factor added for the fact that they have more poor or more sicker people and an obligation. What would that other factor be?

Mr. MARYLANDER. I'm sorry, I must not have expressed myself as clearly.

Mr. NIELSON. That's the way I heard it.

Mr. MARYLANDER. The point I tried to make is that teaching hospitals, like all other hospitals, are under the same motivations to be efficient through the prospective payment system that is now in place for the payment of all Medicare patients, that the indirect passthrough for graduate medical education was provided to account for several additional factors experienced by teaching hospitals that general hospitals do not experience.

Mr. NIELSON. I think we all agree on that, but what should that factor be? Some indication that should not be double, but should be something. Is there some factor between 5.89 and 11.78, somewhere in between? I am trying to come up with all these people at some level. I am not ready to cut it back to 5.89. On the other hand, I am concerned that 11.78 is not doing the job. We ought to find where the level ought to be and find that number.

So since you made the statement that it should be on the same basis as others except for that one factor, I am trying to isolate that one factor in a qualitative sense.

Mr. MARYLANDER. I am sure that the exact number ought to be prepared on the basis of as much sound data as it can, using the most appropriate techniques as can be used. I think that you will be hearing in testimony which will be following from the AAMC the results of the study that they have commissioned which will address specifically that point, and will come up with a specific number that they feel is more appropriate than the administration's recommendations.

Mr. NIELSON. The chairman indicated there is always a problem adjusting up and down when you have these fluctuations. Did you have any difficulty adjusting to the 11.78 from 5.89?

Mr. MARYLANDER. We had quite a bit of adjusting to the 11.6, because of the fact that at the same time as we received the 11.6, we received considerably less for the basic payment for the care of the Medicare patient than we had previously been receiving.

Mr. NIELSON. I am trying to determine is the difficulty in adjustment only when it's down rather than just in general?

Mr. MARYLANDER. No. If all things had been held constant and the only thing that had impacted us had been an increase in the payment, obviously it would not have been difficult at all. But that

was not the case. Between the change of the payment system going from a reimbursement system to a prospective payment system, with all the flaws inherent in that payment system, it made it extremely difficult.

Mr. NIELSON. Do you feel that the DRG system was sufficiently protected? In other words, we know it's a gambler. Sometimes you can have a series of bad cases and really lose money on some of these, and you could actually run out of money in a time or two even on a well-designed one. Was there enough safety factor built into that system to protect most hospitals?

Mr. MARYLANDER. I think the basic problem—one of the problems with the DRG system in that respect is that it was based upon the concept that you would have a distribution of cases that follow—and I am not a statistician, but something of a bell curve, and then we have found that through improved utilization management, there are more and more cases that we would have expected to be less expensive to care for that were not seen in the teaching hospital for a variety of reasons.

Therefore, we are left with the more expensive cases.

Mr. NIELSON. Whereas the regular hospital may have its fair share of easy cases?

Mr. MARYLANDER. I would expect that they would have a better blend than we do, although in their situation as well there is a decline in those cases with the emphasis in transfer of many patients to out-patient care rather than in-patient care.

Mr. NIELSON. My question was, is there enough of a cushion at the bottom to guarantee against ruin, to allow that system to work?

Mr. MARYLANDER. No. In my opinion, there is not. And for many of us, as we continue to move to a national average, it will become even more disastrous.

Mr. NIELSON. Now you mentioned—and Representative Bilirakis raised the question earlier with Dr. Desmarais. He said there is no present incentive to operate a hospital efficiently, since you were paid back on the basis of cost.

Does the AHA have any long-term strategy to prevent reimbursement for direct cost which would provide incentives? In other words, what is your incentive now and how do you plan to operate under the new system?

Mr. MARYLANDER. The bulk of our payment is paid to us under a system which gives us very strong motivation to be as efficient as we possibly can. When we speak of graduate medical education, I assume that is the area in which you are talking about motivation to be more efficient.

Mr. NIELSON. All hospitals, AHA.

Mr. MARYLANDER. I think AHA has said from the very beginning that it supported the prospective payment system as being an appropriate way to encourage institutions to operate as efficiently as possible.

However, when we supported that, we expected the graduate medical education was going to be funded in a manner outside of that prospective payment system.

Mr. NIELSON. I am talking about teaching hospitals only. A statement was made by Dr. Desmarais that there were many schools

which were embarrassed by too much riches on the basis of its increased number. I don't like to harp on the same question, but how many of your teaching hospitals have reported to you that they don't need all the money they were given on this indirect basis?

Mr. MARYLANDER. I'm not aware of any that are experiencing an overabundance of funding.

Mr. NIELSON. On the other hand, how many have told you that they can't make it without an increase in the direct payment?

Mr. MARYLANDER. Many. In fact, in the State of California, we are having some very serious problems with the State schools.

Mr. NIELSON. Would you, for the record, submit lists of schools and lists of hospitals which have that problem, so that we have some idea to work with?

Mr. MARYLANDER. I don't know that I can give you a comprehensive list, but at least within the State of California we certainly can.

Mr. NIELSON. I appreciate that. For the record.

Now I will let you rest.

Mr. MARYLANDER. Thank you.

Mr. NIELSON. Dr. Deal, you mentioned the Federal Government has an important role in targeting resources to specific problem areas in the medical profession. Do you have any specific dollar amount in mind with that statement?

Dr. DEAL. No, sir, I do not.

Mr. NIELSON. Is it more than we do now, or less than we do now, or twice as much as we do now?

Dr. DEAL. We would hope that the programs used to support undergraduate medical education would certainly stay at their current levels and have some of the regulations be augmented a bit, particularly in terms of student loans.

Mr. NIELSON. You don't have any specific dollar amount that you would recommend?

Dr. DEAL. Not today.

Mr. NIELSON. Dr. Riddick, I am familiar with your Oschner Hospital. You have done work in cancer. I appreciate that organization.

Shouldn't there be more hands-on experience in the outpatient rather than the inpatient since most doctors handle people in their office? Shouldn't there be more hands-on experience there?

Dr. RIDDICK. It is certainly appropriate in the primary care fields, which is, of course, one thing that has occurred in our institutions and the multi-specialty group practices that are involved in graduate medical education. There are certain specialties, however, that are high technology or "Gee-Whiz Medicine" sort of things, where all of the action and all of the education must perforce be carried out in the operating room or at the site of the machinery.

Mr. NIELSON. Do you think there is enough outpatient hands-on experience provided for the average doctor?

Dr. RIDDICK. I will tell you the position of AMA on that.

Mr. NIELSON. Take AMA's position; then give me the real truth.

Dr. RIDDICK. I will tell you mine, which happens to coincide with AMA's position, which is that every physician should be broadly trained in aspects of patient care before entering a narrow specialty. For this reason, we have advocated at least a broad general

year before one enters a nonpatient care area or a narrow clinical field.

In that year, the predominant educational experience in such programs as transitional year residencies and primary care residencies are on the ambulatory patient, and in most residences in general internal medicine, pediatrics and family medicine, there is a heavy emphasis on outpatient care.

Mr. NIELSON. Do you provide outpatient care for those who probably won't be involved with outpatients very much? Do they get that general background as well?

Dr. RIDDICK. Our radiologists and ophthalmologists do a fair amount of training in the office.

Mr. NIELSON. What about primary care specialists? Should they be targeted for residency assistance? Should you give them some kind of financial incentive?

Dr. RIDDICK. I think to the extent the current system provides a disincentive for them, it is probably necessary to do so. Title VII did provide targeted funds for that. It was eliminated last year. We would hope that that is restored.

I would also agree with Dr. Heyssel's remarks earlier that if a teaching hospital were faced with a reduction of funds for graduate medical education, probably the ones who would probably suffer are the primary care fields because the bucks are there for hospital care.

Mr. NIELSON. One last question, gentlemen, either you or Dr. Deal.

If title VII were to be cut out on the basis of we have got 35,000 or 70,000, depending on which survey—too many doctors—by 1990, do you agree with the basic premise that we don't need title VII any more, that we don't need to encourage additional medical training in our schools and that the need for it has now passed? Do you agree with that?

Dr. RIDDICK. I personally disagree strongly.

Dr. DEAL. Disagree.

Mr. NIELSON. Do you think 35,000 is any more accurate than the 70,000 we had a year ago? I mean the estimates.

Dr. DEAL. It sounds like a moving target, sir.

Mr. NIELSON. Everything we have had today has sort of been halving and doubling, and I am just curious.

Dr. DEAL. I think we need to continue to look at it and see. As I indicated earlier, I think we have to look at the productivity of each individual practitioner, and I personally think that may be decreasing due to personal reasons.

Mr. NIELSON. You don't really, AMA as a group, feel that there is an excess of doctors or there is likely to be an excess of doctors and therefore it is time to get rid of the title VII.

Dr. DEAL. That is correct.

Dr. RIDDICK. That is correct.

Mr. NIELSON. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Nielson.

Mr. Marylander, Dr. Deal, Dr. Riddick, thank you very much for your testimony and participation in this hearing. We will look forward to working with you as we try to decide what is sound public policy for the Congress to take.

We are now going to break until 1:45, and we will try to start promptly at 1:45 back in this room with the remaining testimony. [Whereupon, at 12:40 p.m. the hearing was recessed, to resume at 1:45 p.m. this same day.]

AFTER RECESS

Mr. WAXMAN. The subcommittee will please come back to order. The committee will now call forward panel No. 3: Dr. John Eisenberg, chief, section of general medicine; Sol Katz, associate professor of general internal medicine, University of Pennsylvania; Dr. Joel J. Alpert, professor and chair, Department of Pediatrics, Boston University School of Medicine; Dr. Marjorie Bowman, program director, family practice residency, Georgetown University Providence Hospital, Georgetown University.

If you would all come forward, please, and take seats. I think Dr. Bowman will be here shortly, I hope.

Please proceed. We have your prepared statements and they will be made part of the record in full. We would like to ask you to summarize your statements.

STATEMENTS OF JOEL J. ALPERT, M.D., ON BEHALF OF AMERICAN ACADEMY OF PEDIATRICS, AMBULATORY PEDIATRIC ASSOCIATION, AMERICAN PEDIATRIC SOCIETY, ASSOCIATION OF MEDICAL SCHOOL PEDIATRIC DEPARTMENT CHAIRMEN, SOCIETY FOR PEDIATRIC RESEARCH; JOHN M. EISENBERG, M.D., F.A.C.P., CHIEF, SECTION OF GENERAL INTERNAL MEDICINE, UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE; AND MARJORIE BOWMAN, M.D., M.P.A., ON BEHALF OF AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. ALPERT. Mr. Chairman, I am Joel J. Alpert. My titles are in my statement. The organizations I represent are also there.

I do want to assure you that I do not work in a hospital that is awash with excessive dollars.

I want to make three major points. Primary care is cost effective. Second, primary care education requires targetted support. Third, targetted congressional efforts to date have been successful in educating primary care physicians.

Much of what I have to say applies to family practice and general internal medicine, as well. However, my comments, as you might well expect, will draw extensively on my pediatric experience.

What is the evidence that we are cost effective? In a number of studies, providing continuous pediatric primary care has led to a one-third decrease in hospital visits, 20 percent decrease in hospital admissions, and a 9 percent decrease in length of hospital stay per admission. This study was accomplished in Baltimore.

Similarly, my colleagues and I in Boston conducted an experiment of families using primary pediatric services. Hospital rates were decreased by one-third without change in the payment mechanism, and when hospitalization did occur, they were 15 percent shorter.

There was a 40 percent decrease in laboratory charges, a decrease in illness visits to the pediatrician, and increase in visits for health supervision, and finally, patient satisfaction was higher. In

short, a utilization shift occurred in the direction of promoting health, and this can clearly be translated into lower patient costs.

With regard to the second point, primary care residencies have enormous difficulty in obtaining financial support. Specialties with high levels of tertiary care receive disproportionate high hospital, medical school and third party payer support for their residents because their revenue is generated from procedure-oriented in-patient services.

Given a choice—and I am told these days that to run a hospital, one must have a hard head and not a tender heart—hospitals will allocate more residency positions in those specialties which bring in more revenues. In institutions such as Boston City Hospital where in recent years it has been necessary to decrease the size of our residency program, a disproportionate share of the cuts has come from pediatric and general internal medicine programs.

We provide services which are ambulatory and in neighborhood health centers and not in the hospital.

At BCH we are reimbursed by Medicaid \$18.50 a visit. Two years ago it would have been \$8.50 a visit. We cannot provide an educational, let alone a service program, with that amount of professional reimbursement. Surprisingly, some pediatrics residents receive support through Medicare's direct payment for resident salary. The usual assumption is that if one is in Medicare, you are not in the pediatric age range.

Because we do not receive the same degree of additional support that other programs do, we depend even more heavily on the indirect adjustment.

The proposed 50 percent reduction would harm primary care residencies disproportionately because the hospitals would, understandably, look to balance this loss of funding by closing out those programs which generate the least amount of revenue.

The third point. Direct Federal support is essential if primary care education is to continue. In 1976 Congress made a commitment through title VII to provide support for residency training in primary care through special projects. These projects have been highly successful. Research done by Dr. Steven Shelov, myself and others has demonstrated numbers almost too good to be true, that 97 percent of those residents trained in the pediatric programs funded under title VII who are practicing are now practicing primary pediatric care. Fifty-two percent of those who practice do so in a rural or socioeconomically deprived urban area, most often in inner cities.

As an educator, simply graduating more physicians does not mean we will necessarily practice quality primary care, nor does it mean we will do it in underserved areas. Targeted support is essential, and the loss of that support would result in the reversal of these gains, and it would, I believe, shift emphasis back to some specialty rather than generalist training.

But even title VII grants are not enough. Many of the faculty necessary to teach the new pediatrics must perform services which are largely nonreimbursable. Behavioral scientists, lawyers, social workers, and economists and ethicists are but a few of the faculty we use in our program for whom funding would be difficult, if not impossible, to obtain, but whose instruction and presence is essen-

tial if pediatricians are to cope with high medical costs, physical and sexual abuse, teen suicide, unwanted pregnancies, learning disabilities, and the broad smorgasbord of grave social problems that place children at risk in 1985. Support for this training must be explicit.

I applaud the proposals to require teaching hospitals to provide a high percentage of primary care residency positions or to support residency training for 3 years. That is not explicit enough.

In the Health Manpower Act of 1976, the Congress directed 50 percent of residency positions to be in primary care. At that time academic medicine responded by pointing out 53 percent of our residents were already there, ignoring, if you will, the fact that many of these residents went on to specialize and did not and do not now provide primary care services.

In summary, then, let me repeat my three points. First, pediatric primary care is effective in lowering medical costs for children. Second, the response to congressional direction under title VII has been successful in educating primary care physicians. And finally, change in financial support for graduate medical education will require continued specific action and targeting to educate physicians who can contribute to disease prevention, health promotion and lowered medical costs.

Thank you.

[The prepared statement of Dr. Alpert follows:]



T E S T I M O N Y

BEFORE THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES
ON
GRADUATE MEDICAL EDUCATION

PRESENTED BY
Joel J. Alpert, M.D., F.A.A.P.
APRIL 3, 1985

Mr. Chairman, I am Joel J. Alpert, M.D., Professor and Chairman of Pediatrics, Boston University School of Medicine and Director of Pediatrics at Boston City Hospital. I am pleased to appear before the committee on behalf of the American Academy of Pediatrics, the Ambulatory Pediatric Association, the American Pediatric Society, the Association of Medical School Pediatric Department Chairmen and the Society for Pediatric Research. My areas of expertise are health care for low-income families and primary care education.

My comments will address three major points: first, primary care is cost-effective; second, primary care education requires targeted support to succeed; and third, targeted Congressional efforts to date have been successful in educating primary care physicians to care for the medically underserved of this country. Much of what I have to say applies to family practice and general internal medicine although the evidence that I will present to you draws upon my pediatric experience.

.) Primary care is the most comprehensive, cost-effective way of providing health care. Primary care reduces the occurrence and subsequent need for more expensive tertiary consultation and inpatient care because primary care pediatricians provide continuous care and become involved in the health problems of their patients early. In this manner, primary care pediatricians practice preventive medicine and thereby reduce the need to use more expensive secondary and tertiary care services later. Primary care pediatricians most often see their patients on an ambulatory, or out-patient basis, and the costs of a visit and treatment for similar clinical conditions are substantially lower than if provided through the more expensive in-patient services.

For example, in a study of a continuity care clinic in Baltimore, Drs. DeAngelis and Gordon and Mr Peterson of Johns Hopkins have shown that providing continuous pediatric primary care led to a 29 percent decrease in visits per 1000 enrollees, and a 20 per-

cent decrease in hospital admissions per 1000 enrollees. There was a nine percent decrease in length of hospital stay per admission.

Similarly, my colleagues and I (in Boston) conducted a randomly controlled experiment which demonstrated significant differences between families seeing primary care pediatricians and those who did not receive this service. For families using primary care services, hospitalization rates were one-third less and when hospitalization occurred, hospital stays were 15 percent shorter; there were 40 percent lower laboratory charges; visits to the pediatrician for illness declined significantly, and visits for health supervision increased; and finally, patients' satisfaction was higher. In short, a utilization shift occurred in the direction of promoting health, and this can be translated into lower patient costs.

These data show the clear advantage of continuity of care provided by primary care pediatricians, and the clear cost advantage of primary care over other more expensive in-patient care services. Thus, a strong case can be made for supporting primary care as an essential element of a complete health care delivery system.

- 2.) Unfortunately, primary care residency programs have enormous difficulty in obtaining the financial support they need to train primary care physicians. Traditionally, specialties with high levels of tertiary care and procedure-oriented, hospital-based practices, such as surgery and anesthesiology, have received disproportionate hospital, medical school and third-party payer support for residents. This is in large part because of the revenue generated from their procedure-oriented, in-patient services.

Given a choice, hospitals will allocate more residency positions in those specialties which bring in more revenue. In institutions such as Boston City Hospital where it

has been necessary to decrease the size of our resident staff, a disproportionate share of the cuts has come from pediatric and general internal medicine programs. This is because we provide services which are largely ambulatory and in neighborhood health centers, rather than in the hospital, so they do not bring in a large amount of revenue. At Boston City Hospital, pediatricians are reimbursed \$18.50 per visit, regardless of the length and nature of the visit. We cannot manage an educational, let alone a service program, with that amount of professional reimbursement.

Primary care residents in pediatrics do receive support through Medicare's direct payment for resident salaries. Because they do not receive the same degree of additional support that other programs do, however, they depend more heavily on the support that teaching hospitals get through Medicare's indirect adjustment. Therefore, the proposed 50 percent reduction in the indirect adjustment would harm primary care residencies disproportionately because the hospitals would look to balance this loss of funding by closing out those programs which generate the least amount of revenue, namely, primary care.

) Since training programs for the most cost-effective form of health care delivery -- primary care -- have enormous difficulty achieving even inadequate financial support, federal support is essential if primary care education is to continue and its quality is to be maintained.

In 1976, Congress made a commitment to provide primary care residency training through special projects under Title VII of the Public Health Service Act. Evidence is clear that the programs and trainees funded by these grants during the past several years have been highly successful.

Research done by Dr. Steven Shelov (Albert Einstein School of Medicine), myself and others for the Ambulatory Pediatric Association demonstrates how effective Public

Health Service grants have been in developing quality pediatric residency programs. Ninety-seven percent of the residents involved in these programs have gone on to practice pediatric primary care; 52 percent of these pediatricians serve in rural or socioeconomically deprived urban areas, (areas that are traditionally underserved by more specialized physicians), thereby providing access to medical care for an even greater number of underserved children and families.

These data are not an isolated finding -- they have been confirmed, not only in other pediatric settings, but also in studies of family practice programs, where 75-90 percent of the physicians become primary care providers.

Logic argues that the success of these programs in meeting the goals Congress set for them warrants their continued funding. As a practicing physician and medical educator, I know that simply graduating more doctors does not mean they will necessarily practice primary care, and do so in geographically underserved areas. Thus, targeted support for programs like the Public Health Service grants are essential if we are to address these manpower problems. The loss of grant support for these primary care training programs would result in a reversal of many gains in physician distribution but, more important, would shift emphasis back to subspecialty rather than generalist training.

However, Title VII grants alone are not enough. Only a small percentage (15 percent) of pediatric residents currently benefit from these programs, and more federal support is needed to guarantee the development of other successful programs. Many of the faculty necessary to teach the broadened aspects of the "new pediatrics" effectively must perform services which are largely non-reimbursable. Behavioral scientists, social workers and ethicists are but a few of the many kinds of faculty for whom funding is difficult if not impossible to obtain, but whose instruction is essential

if pediatricians are to cope with child physical and sexual abuse, teen suicide, unwanted pregnancies, learning disabilities and other grave social problems that place children at risk. Support for this type of training in pediatric primary care residency programs must be explicit if it is to be maintained, let alone increased.

Federal support is also necessary if the number and quality of primary care pediatricians is to improve. While I applaud the various proposals to require a teaching hospital and its affiliates to provide a high percentage of primary care residency positions, or to pay residents for three years only and thereby seek to increase the number who train in primary care, these proposals are not explicit enough. It is unlikely that the present environment in teaching hospitals will lead them to support primary care residency programs without strong financial incentives toward these goals. In the Health Manpower Act of 1976, Congress directed 50 percent of residency positions to be in primary care. At that time, simply by adding the number of residents in pediatrics, family practice and internal medicine, academic medicine responded that 53 percent of residents were already in primary care, despite the fact that many of these residents then went on to specialize and did not, and do not now provide primary care services.

History shows that any attempt by the federal government to mandate primary care physician development would be effected in name only, unless some kind of incentive or enforcement mechanism is included. Congress must target funds for program and faculty development and must follow through to make sure that primary care residency programs actually develop high-quality primary care physicians. While this effort is being developed and implemented, continued federal support for residency programs through Medicare direct and indirect payments, and through Title VII grants is essential for successful disease prevention, health promotion and lowered medical care costs.

In summary, may I reiterate these three major points:

- 1) Pediatric primary care is effective in lowering medical costs for children.
- 2) The response to Congressional direction under Title VII has been successful in educating primary care physicians.
- 3) Change in financial support for graduate medical education will require continued specific action for these accomplishments to continue.

Mr. WAXMAN. Thank you very much.
Dr. Eisenberg.

STATEMENT OF JOHN EISENBERG, M.D., F.A.C.P.

Dr. EISENBERG. Thank you.

Last year when I appeared before you, I emphasized, as we were talking about the title VII bill, how those grant programs needed to be considered in the context of two other larger issues. One was how graduate medical education is funded, the topic today, and the other is the kind of financial incentives that greet those physicians when they go into practice.

I want to thank the subcommittee for the important role it played in assuring the continuation, at least as much as Congress could do, of those grants programs under title VII in very tough budget circumstances last year.

I also want to thank the subcommittee for recognizing that in the context of budgetary policy decisions being made by the Congress today, that health policy decisions must be kept in mind, and I appreciate the chance today to think about those issues.

I see the issue of graduate medical education financing that faces us today as an exciting opportunity. I think it is a chance, now that we are rethinking this issue, to be sure that the way in which we pay for residency training is consistent with overall health manpower policy of the Nation.

I speak as an internist. The rest of us speak from our own particular perspective, but I think all of us speak as primary care physicians, from the same point of view.

One of the first questions that anybody is going to ask us and we hear all the time is: Why should we be paying for the education of a group of professionals who are highly paid and might be in oversupply in the future?

My answer to those people is twofold: That those are exactly the reasons that we should be paying for graduate medical education but doing so in a very targeted way. First, the financial attraction of certain types of practice are currently presenting a potential obstacle to those of us in the primary care specialties where we are dealing with students of increasing debt who are looking at reimbursement patterns when they leave that will make it difficult for them to pay those debts, and we are having more trouble attracting those residents to our specialties.

So that the high payment for physicians in our society today reasonably should be involved in financing graduate medical education. Similarly, a larger number of doctors is a rationale for Federal involvement because it is really a reminder to us that we need to intensify our efforts to educate those physicians, those increasing numbers of physicians in a way that is consistent with where we want our health policy to go.

The problem is not we don't have enough doctors, as you know. The problem is really what types of doctors we want to train and how they get trained.

Now let me comment on the way in which doctors are paid because I want to emphasize something that was mentioned this morning. That is, the bulk of residency salaries are generated by

the care of hospitalized patients, not just the resident salaries but also the payment of the teachers and the settings in which they occur.

In exchange for that payment, residents provide service for hospitalized patients. We will not be able to pay for our residents teaching out of outpatient revenues, and we need to come to some remedy which will allow us to pay for outpatient teaching. Residents require a substantial amount of supervision, and teaching in an outpatient setting, they are inefficient because they are new physicians, they are often practicing in settings that take care of indigent patients and those with complex and chronic diseases.

For all those reasons, we are not, without some sort of subsidy for ambulatory care education, able to educate them in that setting.

Now, the hospital administrator who looks at the current situation would logically turn to his chief financial officer and say, what should we do about ambulatory care education? The CFO would remind him about how much money they are losing in that setting. So we do need continued financing of graduate medical education and what it provides us with those incentives.

Let me try to also address two concepts that were raised this morning that I think are misconceptions. One of them is an issue about the free market providing an opportunity for us to let laissez-faire economics drive the health care training system in a way that might be consistent with our overall policy.

I have often heard it said that the invisible hand of health economics is all thumbs, and I think that that is the case today. If we look at the invisible hand of health economics right now, it is, in fact, having some very interesting impacts in internal medicine training.

In 1977 through 1978, 75 percent of internal medicine residents went into subspecialties. Then we started to see some improvement in 1981 to 1982. Fifty-six percent, down from 75 percent, were going into subspecialties, a large increase in the number going into general internal medicine; but in the last couple of years, 1982 through 1984, we have seen a disconcerting increase in the number going into subspecialties again.

Those of us who are in internal medicine ask not only the question about why that is happening, but why family practice residencies are flat in terms of the numbers they have. Internal medicine dropped a little. Now we are flat again. Pediatrics has not enjoyed an increase in the number of residents entering those specialties, but other specialties have.

We are convinced the reasons are several-fold. One is the debts that students are facing today, and the opportunity for paying off those debts more easily in certain specialties, certainly not family practice and general internal medicine and general pediatrics.

Also, because of the fact that there has been a plateau in the title VII funding of the residency programs, it is probably not a coincidence that in 1977 through 1982 we had an increase in the number of people going into general internal medicine at the time that the Federal programs were paying for those residency programs.

The Federal Government and foundations are now keeping that funding level or decreasing it, and consistent with that and the other factors that I mentioned, we are seeing a very disconcerting phenomenon, which is the start of going back to the increasing numbers of subspecialty trainees that we had in the past.

For general internal medicine and for general pediatrics, our task is to change a specialty, a specialty which we think we can change, but we need help in doing so, and much of that assistance can come from government through the incentives of graduate medical education financing.

Although I think there are five principles in the way we can do that, one of them is graduate medical education is fundamentally linked with patient care. Three-quarters of residents' time in this country is spent on actual patient care, and we can't forget that, but I don't think that it makes sense to suggest that we ought to staff inner city hospitals with residents because of the fact that they provide important care.

The answer is, if we have inner city hospitals that need to have more physicians, we need a reimbursement system which will induce physicians to practice in those inner city hospitals, not a turnover of fresh, young residents every three years to practice in those settings.

We need to have a situation where the residents can be trained in primary care specialties with an inducement not to just train them as inner city hospitals but to stay in those neighborhoods once they finish, which currently they seldom do.

Graduate medical education also serves the public good. I want to echo what was said this morning by Dr. Heyssel about our concern about all payers and all providers helping to pay for graduate medical education. The teaching hospitals and the teaching practices are becoming less competitive because of the burden of medical education costs that they carry and the fact that their competitors are not carrying those costs.

So we are seeing the patients starting to shift away from the teaching hospitals, in part because of our higher costs, which is in part because of our responsibilities for education.

I am concerned by the HCFA response, which seemed to me to be one of, well, everyone else is jumping ship; why don't we jump ship too? It seems to me a more responsible Federal response would be to say let's be sure that all payers and all providers share in the cost of providing high quality physicians in the future.

We also hear it said that recipients of graduate medical education should bear part of the financial burden, that the residents themselves should. I want to suggest they already are. Recent work has suggested \$20,000 a year as the average salary of residents in this country, and they work 74 hours a week. My calculation is that is \$5.40 an hour, which is a pretty low wage. I think the residents are sharing a substantial part of the cost of graduate medical education, accepting the low market wages, working long hours.

I want to just reemphasize that I don't think we should separate our national health manpower policy from our policy for graduate medical education, and I hope that when we think about the number of residents that we need, we think about some of those issues that were addressed this morning about the incongruity of

the Federal Government paying for graduate medical education, the numbers in excess of the number of graduates of accredited programs.

Finally, I want to suggest that the teachers of these residents will not be able to take up the cost of paying for them. Many have suggested that we ought to let the residents work for physicians and that the physicians pay the residents' salary. Given our current reimbursement system, it simply won't work in certain fields where the physicians are not paid enough to be able to pay for the residents as assistants.

It won't work for the three of us and the physicians that we represent.

So let me offer to the subcommittee the assistance of two societies—one, the Society for Research in Education in Primary Care and Internal Medicine; second, the American College of Physicians—to work with you to develop a way of paying for graduate medical education that will accomplish six goals.

First, it will encourage training in the primary care specialties. Second, it will encourage the type of education within those specialties that is in keeping with the goal of training doctors who are committed to cost-effective care, high quality care, comprehensive personal care that emphasizes prevention, and in the long run, I think, will decrease health care costs.

Third, it is not biased against indigent young physicians. Fourth, it encourages the development of innovative ways of teaching medicine, which I haven't emphasized heretofore but, I want to state, is a spinoff of the kind of funding that we have for primary care specialties. Much of the research that is done into innovative ways of delivering care is done by those faculty who are in those teaching settings.

Fifth, we should assure the opportunity for residency training for graduates of accredited medical schools. Sixth, we should encourage rather than discourage physicians from participating in teaching programs. This should occur in the context, of course, of a continuation, I believe, of the grants program which provides funding for items which will not be in the near future paid for by reimbursement for graduate education, particularly the development of curricula, teaching materials, preparation of faculty.

Until the reimbursement system is properly realigned, I hope we can reauthorize the funding for primary care, internal medicine, pediatrics and family medicine training programs.

I want to emphasize something important. That is, in internal medicine today, less than 10 percent of residencies receive this training. It makes a big difference in those institutions—and they serve as leaders in our specialty—but more than 90 percent of residencies in our specialty do not have training funds for primary care through the title VII program.

I appreciate the opportunity to share my concerns with you, and more than that, I think, to share with you my enthusiasm for the opportunity that we have in front of us to provide some incentives rather than some disincentives to primary care training.

[The prepared statement of Dr. Eisenberg follows:]

STATEMENT
BEFORE THE
HOUSE ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

April 3, 1985

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am John M. Eisenberg, M.D., F.A.C.P., a board-certified internist and Chief of the Section of General Internal Medicine at the University of Pennsylvania School of Medicine. I was asked to offer these comments by my colleagues in the country's organization of 1100 teachers of primary care Internal Medicine, the Society for Research and Education in Primary Care Internal Medicine, of which I am a past president. I also speak on behalf of the 60,000 member American College of Physicians, which is the leading organization of internists in our country and of which I chair the Health Care Financing Subcommittee.

Last year I spoke before you about the importance of the Public Health Service's grants program for primary care residency training in General Internal Medicine and General Pediatrics. At that time, I emphasized that these grants programs must be considered in the context of two larger pictures: first, how graduate medical education is funded in our country; second, once those residents have finished their training, what financial incentives exist to induce them to practice cost-effective and high quality primary care.

Today I want to focus my comments on the first issue -- the financing of residency training in Internal Medicine. As the Congress reconsiders

the fundamental principles that govern financing graduate medical education through Medicare and Medicaid, we have an exciting opportunity to assure that our nation's policy of paying for residency training is consistent with its overall manpower policy. Although I speak as an internist who practices and teaches primary care Internal Medicine, the principles that I espouse are applicable to the other primary care specialties as well.

One of the first questions that occurs to you today when thinking about financing graduate medical education is, "Why should we be paying for the education of a group of professionals who are highly paid and who may be in over-supply in the near future?" My answer is that these are just the reasons that the federal government should be involved in graduate medical education. The financial allure of certain types of medical practice is now becoming a potential obstacle to our ability to recruit medical students to training in primary care specialties. These specialties, with their lower expected incomes, need help. The fact that there will be larger numbers of physicians in the future than there are now only emphasizes the need for us to intensify our efforts to educate these doctors to practice personal, comprehensive, cost-effective care, with an emphasis on prevention. In addition, it is the teachers of primary care who have done much of the research on prevention and cost-effectiveness in clinical practice. For sure, the problem now is not one of enough doctors. The problem is what types of doctors we will have and how are they educated.

First, let me comment on the way that young doctors are paid during their residencies. As you know, the primary care specialties of Internal Medicine, Pediatrics, and Family Practice all require three years of training, with some individuals continuing for two or three additional years of subspecialty training. Today, I want to discuss the first three years of residency education in Internal Medicine which prepare young doctors for careers as general internists. About 70% of the funding of these residents comes from patient care and general operating revenues of hospitals. Only 13% comes from state and local governments. Therefore, the bulk of residents' salaries is generated by the care of hospitalized patients. In exchange for that payment, residents provide service to these hospitalized patients. When we turn our attention to the important area of outpatient training, we ask the question, "Can residents' salaries be paid from outpatient revenues?" Almost always the answer is, "No". Many of the patients who are cared for in our teaching hospitals are the indigent, or patients with complex and chronic diseases who have been cast aside by other physicians. In addition, residents require a substantial amount of supervision and teaching, which added to the inefficiency of being a new doctor, means that these hospital clinics will rarely, if ever, have surplus funds to pay their residents' salaries.

This combination of the large bulk of residents' salaries emanating from inpatient revenues and the usually deficit financing of ambulatory care programs in teaching hospitals produces a squeeze that I'm sure you can imagine. In an increasingly competitive and cost-conscious era, the hospital administrator must have very strong motivation for supporting an educational program in the outpatient arena when his chief financial

officer is continually reminding him of how much money they are losing there.

I would like to make the case that we not only need continued financing of graduate medical education, but also that we need to assure that this financing is arranged in a way that will produce incentives for more, not less, education of residents in learning how to take care of patients out of the hospital, how to prevent disease, and how to provide comprehensive and continuous care to their patients. Medical educators have always prided themselves on teaching their students the science that will be, not the science that is. In a similar vein, we need to assure that medical educators are training residents for a practice that will be, instead of a practice that is.

Let me take a few minutes to state five principles of graduate medical education that I think should be basic tenets for policy decisions.

First, graduate medical education is fundamentally linked with patient care. As much as we will continue to try to distinguish the cost of medical education from the cost of medical service in residency programs, the two are inextricably intertwined. Recent research shows that about three-quarters of residents' time is spent in actual patient care. Therefore, we should continue to use patient care revenues to pay for residents' salaries in this country. Certainly, the medical schools, which have been forced to increase their tuitions to already exorbitant levels, will not be able to pay for graduate medical education. Just as the cost of on-the-job education in other complex professions and industries is woven into the price of the product, whether it be the computer

that I buy or the lawyer's fee that I pay, Medicare and Medicaid should continue to pay for the service that is performed by our residents.

In addition to graduate medical education being interwoven with patient service, a second principle is important. Graduate medical education serves the public good. High quality medical care is a valuable national resource, and I believe that our nation is healthier for the quality of our medical care. I believe that the quality of medical care is better in a large part because of graduate medical education. Not only quality of care in our teaching hospitals, but also the quality of care in our community hospitals, our HMO's, our military, our Veterans Administration, and in our growing for-profit sector has benefitted from our graduate medical education programs. It bothers me that the cost of medical care in our teaching hospitals, which is due in part to their teaching function, is making them less competitive than those hospitals and other providers that take advantage of the product of the teaching hospitals -- well-trained young doctors -- but do not share in the cost of their education. The fact that they can avoid the cost of educating their future staff, makes these other providers all the more competitive. I believe that all payers should share in the cost of graduate medical education. Our teaching hospitals serve as a national resource not only because they train our future physicians, but also because they provide a fertile ground for advances in medical knowledge, help us understand the value of new technology that is emerging, and because they serve as centers of continuing education for practicing physicians.

I have said that I believe that graduate medical education should be financed in part because residents provide a service. I have also said that graduate medical education's service of the public good is a reason that our nation should pay for graduate medical education. I also believe that the recipients of graduate medical education should bear part of its financial burden. In fact, they already do. Research published this winter showed that a typical resident is paid about \$20,000 per year and works a 74-hour work week. My rough calculations suggest that this is a wage of about \$5.40 per hour. Compare this wage, not to mention the psychological cost of the intensive training required to produce a quality physician, with the kinds of salaries that other equally talented individuals are earning seven to ten years after high school. Indeed, our nation's residents are already paying a substantial share of the cost of medical education by accepting below market wages and working arduous hours.

My fourth point is that we cannot separate our policy about paying for graduate medical education from our nation's manpower policy. It makes little sense for us to help hospitals pay for residents according to the number of inpatients they take care of when we are trying to de-emphasize hospital-based care, and when we are trying to emphasize the training of physicians who will be capable of taking care of their patients out of the hospital, or even preventing their patients' ever needing to be admitted. The financing of graduate medical education should not be driven only by the service needs of the hospital to care for acutely ill patients. It should also be driven by the needs of our country for physicians in the various specialties and with various types of training. Another important national health manpower policy has to do

with assuring that individuals from economically disadvantaged backgrounds have an opportunity to practice medicine. With the increasing debt burden of our medical students today, it concerns me to hear of proposals suggesting that residents pay for the part of their residency that is education. Another important issue in our national health manpower policy is the number of foreign medical graduates in this nation. We have about 17,000 individuals graduating from American medical schools. There are about 22,000 residency positions available. This means that there are about 5,000 positions for individuals who did not graduate from accredited medical schools, and this produces a vacuum into which foreign medical graduates flow. If we are concerned about providing an opportunity for graduate education for American medical students and simultaneously concerned about the potential over-supply of physicians, one of the first places that we should direct our attention is the incongruity of the federal government paying for graduate medical education for numbers in excess of the number of American medical graduates.

Finally, the teachers of residents will not be able to shoulder the burden of paying for residents' salaries with current physician reimbursement. Certainly, there are some teaching physicians who can afford to pay their residents' salaries. And who are they? They are physicians who are practicing in the most lucrative specialties. These are mostly hospital-based specialties with large billings for operations and procedures. In the primary care specialties, we already are asking physicians to donate their time to teach. We are asking them to accept medical students and residents in their private practices, which inevitably slows them down but enables the residents to experience

something other than the inner-city hospital clinic. We are asking them to develop curricula, to teach, and to prepare their teaching in their free time. The Congress will recognize that also asking these teachers to bear the burden of their residents' salaries will certainly discourage ambulatory care education, will especially discourage education in the primary care specialties, and will discourage practicing doctors, especially in community hospitals, from donating their time to teaching young doctors. Training in home care, which is being introduced in many residencies, presents even greater difficulties in financing the educational costs.

Based on these principles, let me offer to the Subcommittee the assistance of the Society for Research and Education in Primary Care Internal Medicine and the American College of Physicians in working with you to develop a way of paying for graduate medical education that:

- (1) encourages training in the primary care specialties;
- (2) encourages the type of education within these specialties that is in keeping with the goal of training physicians who are committed to cost-effective, high quality, comprehensive personal medical care that emphasizes prevention -- in particular, ambulatory care education;
- (3) is not biased against indigent young physicians;
- (4) encourages the development of innovative ways of teaching medicine;
- (5) assures an opportunity for residency training for graduates of accredited medical schools; and
- (6) encourages, rather than discourages, physicians from participating in teaching programs;

This new mechanism of financing medical graduate education should be coupled with a grants program for the development of innovative curricula,

teaching materials, and the development of faculty who can provide the leadership for graduate medical education in the years to come. Grant assistance will also be necessary because of the deficit that will continue to exist in primary care residency training if reimbursement of education and ambulatory care does not change. It is important that the grants program for residency training in General Internal Medicine and General Pediatrics be reauthorized until the reimbursement system is realigned in a way that will encourage primary care education. We need these grants to assure that there is no decline in the progress we have made so far while we are devising new ways of financing graduate medical education with an emphasis on primary care.

However we decide to finance graduate medical education, it should be in the context of what comes before it and what comes after it. Namely, graduate medical education cannot be considered without also considering the serious implications of the burden of debt for our medical students who are entering residency programs on the one hand, and on the other hand the type of physician reimbursement system which will greet these residents as they enter practice and which will send them a clear message about the kind of medical care that this country's payment systems want to reward.

I appreciate the opportunity to share with you my concern and my ideas about the impact of financing graduate medical education on the training of primary care internists. I would be pleased to respond to any questions which the subcommittee might have.

Mr. WAXMAN. Dr. Bowman.

STATEMENT OF MARJORIE BOWMAN, M.D., M.P.A.

Dr. BOWMAN. Thank you. I am pleased to be here to present the view of the American Academy of Family Physicians and the Society of Teachers of Family Medicine. I think much of what I will say will be to reiterate those positions of my colleagues (Drs. Alpert and Eisenberg) and to highlight the issues as we see them.

I think the combination of the prospective payment system that has been put into place and the administration proposals having to do with reimbursement for graduate medical education and with title VII budgetary issues would be devastating to primary care specialties. And I think that goes for all of us primary care specialties.

The current incentives in the system just are not for hospitals to consider the national good when they decide who and what kind of residencies they have, and our specialties are particularly expensive for hospitals to have.

I would first emphasize that the American Academy of Family Physicians and the Society of Teachers of Family Medicine believe strongly that support of graduate medical education is an appropriate role for the Federal Government. Graduate medical education should be supported by patient care funds, and the Medicare-Medicaid Programs should support their fair share.

As was discussed earlier today, I think all payers should carry their fair share. I would note that governmental support for family practice programs has been vital to the growth that has occurred in the last decade. Such Government support is essential for the maintenance of the programs that have been developed.

I previously did a statistical analysis of what occurred in family practice in relationship to Federal funds, and it was clear that when more Federal moneys went into the family practice, more residencies and more residents existed. And, when there has been no further increase we have leveled off, as was mentioned earlier.

Family practice residency programs fill an essential societal need by producing well-qualified family physicians able to provide cost effective, comprehensive and continuing care to all members of the family regardless of age, sex, medical problem, or organ system involved.

Data show that our graduates are located in underserved areas both in the inner city and rural areas. About 98 percent of physicians who complete family practice residency programs stay in family practice, rather than subspecialize. Federal financial support has had a significant impact on family practice education, which ultimately benefits the patients.

However, the current proposals will jeopardize the future of these valuable programs. As resources become more scarce in teaching hospitals, they are going to, in turn, squeeze or eliminate primary care training programs.

Someone mentioned earlier they had decreased their number of residents. In my own program we are decreasing our number of residents as our hospital is becoming financially pressed.

Any reductions will force teaching hospitals to reassess their commitments to graduate medical education and to specific types of specialties. They can be expected to maintain those programs which generate the most revenues and reduce or eliminate those which tend to be loss leaders, such as primary care.

Those programs, such as primary care that emphasize ambulatory services and cost containment simply just do not generate adequate income.

Third-party reimbursement falls short as a financial foundation, because such coverage has a bias toward inpatient care. Family practice residency programs emphasize ambulatory care, disease prevention, health promotion and cognitive services contributing to better health care, but not better patient care revenues.

We believe that major reductions in Medicare reimbursement for medical education which do not include reforms to adequately take into account this bias will result in significant decreases in programs. And this has been verified by discussion with other residency directors. Our national office gets calls almost daily from family practice residency directors saying they are having financial problems, they are being squeezed under the current system. And, in this last year, approximately a dozen family practice programs had announced that they will be shutting down either directly or indirectly as a result of financial pressures.

Any changes in the financing of graduate medical education therefore need to be developed carefully and thoughtfully with attention to the long-term policy implications. I think the long-term policy implications of the current proposals are that there will be more subspecialty residencies and fewer primary care residencies, and that will be very costly to the system.

I would also like to comment on the GMENAC study which has been frequently mentioned here. And that is, if you look at GMENAC, who said there was going to be an oversupply, they said there would be a near balance of the primary care specialties. Also, in the assumptions, it said that the near balance was based on the fact that there would be continued production at current levels and with the current proposals that would no longer occur.

Also in GMENAC, if you look at it, who is oversupplied?

Those specialties that are paid extremely well. The higher paying specialties tend to be those that are oversupplied. The primary care specialties and psychiatry share the bottom of payment and income for physicians. And, I think you see that reflected in terms of where medical students go.

I would like to say a little bit about my own residency program to indicate how this occurs. We are based at a community hospital, and our hospital has been affected by the prospective payment system and the other changes that are happening in the medical care system. As a result of this, they have had to cut budgets. So, what have they done?

Well, they firmly believe they are not cutting quality of care. They are increasing their efficiency. There is pressure to reduce indigent care, and there is pressure to reduce graduate medical education programs.

In the last few years our Residency Program has absorbed losses that occurred by loss of a private foundation grant that partially

supported our outpatient center, and loss of a training grant that supported one aspect of our program. And now we are being asked to absorb many additional costs associated with our outpatient center.

I am concerned in the long term, what that is going to mean to us and whether we will be able to exist unless there is a reversal of what has been proposed.

I would like to thank you very much for the opportunity to be here. I am pleased with your concern for the funding of graduate medical education.

[The prepared statement of Dr. Bowman follows:]

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS
BEFORE THE SUBCOMMITTEE ON HEALTH AND ENVIRONMENT
ON THE SUBJECT OF GRADUATE MEDICAL EDUCATION

PRESENTED BY

MARJORIE BOWMAN, M.D., M.P.A.

On behalf of the American Academy of Family Physicians, I am pleased to be here today to share with you our views on the issues of graduate medical education. Considerable discussion currently is taking place in the Congress and the Administration with respect to the federal role in financing of graduate medical education. For primary care specialties such as family practice, this debate and its eventual outcome are critical to the future of the profession.

The issue is a complicated one, with several elements intertwined--Medicare payments for both direct and indirect medical education costs, Public Health Service grants for support of primary care and family practice training programs and Medicare physician reimbursement. For primary care programs in particular, the funding of residency training programs is affected by each of these components.

We would first emphasize that the American Academy of Family Physicians believes strongly that support of graduate medical education--both through the Medicare program and the Public Health Service grant program--is an entirely appropriate role for the federal government. Graduate medical education should be supported by patient care funds, and the Medicare program should pay its proportionate share. In particular, we would note that family practice residency programs fulfill an essential societal need by producing well qualified family physicians, able to provide cost-effective comprehensive and continuing care to all members of a family, regardless of age, sex, medical problem or organ system involved.

Congressional concern about the lack of physicians to provide general, primary care led Congress to identify as a priority of the federal government the need to increase the numbers of family physicians in the early 1970s. The Comprehensive Health Manpower Training Act (P.L. 92-157) was enacted in 1971, mandating the establishment of a grant program to provide residency training in family medicine, and the Health Professions Educational Assistance Act of 1976 (subsequently reauthorized) continued the federal commitment to primary care training programs. Governmental support for family practice programs over the past decade is largely responsible for the development and growth of this specialty. And such governmental support is essential for the maintenance of the progress that has been made in this discipline.

The continued need for federal support for family practice training programs stems from several factors. In past testimony before this committee the American Academy of Family Physicians has described that federal funding is uniquely vital to the operation of family practice programs because the residencies are themselves unique. They do not fit the traditional graduate medical education mold and, as such, cannot live up to what one independent study from the University of Missouri at Columbia called the "unspoken expectation...that primary care education, in common with other graduate medical education, ultimately must be supported largely from patient care income." The study, "Patient Care Income and the Financing of Residency Education in

Family Medicine," documents what family medicine educators have been facing: uncontrollable factors keep costs high and patient care income low. It notes that while traditional theory holds that approximately one-half of graduate medical education programs' costs should be recoverable through income from patient care services, reality shows that this is an unrealistic expectation for family practice. Studies done by both the Health Planning Resource Center at the University of Wyoming and the University of Missouri at Columbia estimate that the average family practice residency generates approximately 20% of total program costs through patient care revenues.

One of the reasons that family practice income is low is due to Medicare reimbursement policies and other reimbursement policies that are frequently modeled after Medicare. Third-party reimbursement falls short as a financial foundation for family practice training because such coverage has a bias toward inpatient care. Those skills and procedures which are taught to family practice residents, and which emphasize ambulatory care and disease prevention, contribute to better health and more cost-effective health care, but do not generate patient care revenues sufficient to underwrite graduate training in family medicine. Through the efforts of this Congressional Committee and others, the Office of Technology Assessment is currently studying several issues surrounding Medicare payment to physicians, including the differential in Medicare payment for cognitive services as compared to procedural services. It is hoped that the findings

of the OTA study will provide the impetus for a resolution in the inequities that exist between reimbursement levels for procedural versus cognitive services. Such changes in the Medicare payment system would be beneficial in assisting family practice residency programs to generate a greater percentage of revenues from patient care income. However, it is not known at this time if these unique residency programs, with their emphasis on ambulatory care, can ever compete financially with inpatient-based residency programs and reach a point where targeted federal assistance is no longer necessary.

I would now like to address the Public Health Service grants which provide support to family practice education. In FY 1985 Congress appropriated \$36 million (with \$2 million for general dentistry) for Section 786 of the Public Health Service Act which authorizes support for family practice residency programs and programs to train teachers of family medicine. This funding currently supports 189 graduate projects, 63 predoctoral projects and 35 faculty development projects, for a total of 287 projects. Congress also appropriated \$7.5 million for Section 780 of the PHS act which authorizes support for departments of family medicine within medical schools. This funding currently supports 61 projects. We believe that it is evident that a relatively small amount of federal dollars is having a sufficient impact on family practice education in the United States, and is benefiting patients throughout the country. The following data concern the practice locations of family practice residency graduates, and the

percentage of graduates who stay in the specialty of family practice. Data clearly show that graduates of family practice residency programs are locating their practices in rural as well as urban areas. Approximately 50% of the family practice graduates entered practice in communities with populations of 25,000 or less, and over half of these are located in areas not within 25 miles of a large city. This compares with approximately 11% of physicians in other specialties who enter practice in non-metropolitan areas. Survey responses from 1,519 individuals who completed family practice residency programs in July 1983 suggest only a small percentage may enter some other specialty, with 1.9% (30) reporting they were planning to take further training. By contrast, according to a Society for Research and Education in Primary Care Internal Medicine report, 53% of internal medicine residents who completed training in 1981 opted for subspecialization.

Last October, the American Academy of Family Physicians, concerned about potential cutbacks in federal funds for training programs in family medicine, mailed a brief questionnaire to 383 directors of family practice residency programs to garner some idea of the potential effect of withdrawal of these funds. A total of 335, 87.5 percent of the program directors responded, with 51% indicating that their programs receive federal support (184 programs) either directly or indirectly through a medical school or other source. Among these programs receiving federal support, 59% of the program directors indicated that elimination of funds would cause a reduction in the number of faculty and support

staff; 48 percent indicated that there would be a reduction in the elements of the curriculum, and 24% indicated that a reduction in the number of residents would result. While this information is, by its nature, subjective, we believe it is indicative of the potentially serious impact of the withdrawal of federal funds from family practice training programs. We would specifically emphasize that any proposals under discussion which would eliminate the PHS training grants would seriously disrupt family practice and other primary care training programs, those programs which Congress has for the past several years targeted for special support because of their particular financing difficulties.

This brings me to the discussion of Medicare financing of graduate medical education. The AAFP is deeply concerned about proposals by the Administration and by the Senate Budget Committee which would freeze the direct medical education payments and reduce by 50% the indirect adjustment. As resources of teaching hospitals become more scarce, the potential for the elimination of family practice and other primary care training programs increases. Specifically targeting the Medicare medical education payments poses an additional burden for these programs. While graduate medical education programs greatly enhance the quality of care in teaching hospitals, they add significant costs. Major reductions in the indirect medical education payments coupled with a freeze in the direct medical education payments will force most teaching hospitals to reassess their commitments to graduate medical education. As hospitals reassess these

commitments they can be expected to maintain those programs which generate the most revenue and to reduce or eliminate those programs which tend to be financial loss leaders. This will be particularly true for those hospitals which are being increasingly squeezed financially by the DRG system. Family medicine and other primary care programs will not fare well. These programs emphasize ambulatory services and cost containment and simply do not generate adequate income in the current reimbursement system to be financially attractive to teaching hospitals. Hospitals, facing budget constraints, will have few incentives to retain family practice and other primary care programs. In 1984, over a dozen hospitals indicated their decisions to eliminate their family practice residency programs. Financial uncertainties in funding graduate medical education have contributed in a major way to these decisions.

Some in Congress are sufficiently sensitive to the contributions of primary care that they are trying to develop incentives for these programs utilizing the Medicare direct medical education payment, such as proposals which would require a certain percentage of residencies to be in the primary care specialties and others that would fund only three years of residency training programs. However, in these approaches, we must bear in mind that any incentive must have a financial commitment to family practice programs which, for the reasons cited above, are not self-sufficient.

We believe that the impact of major reductions in Medicare reimbursement for medical education which do not include reforms to take into account primary care programs may well be a significant decrease in these programs--a result which is not consistent with sound health policy. Any changes in the financing of graduate medical education should therefore be developed carefully and thoughtfully, with attention given to the long term policy implications as well as to the short term budget savings.

The American Academy of Family Physicians is therefore pleased that this subcommittee has indicated its willingness to thoroughly study the issue and we stand ready to assist you in this effort. We appreciate your sensitivity to the concerns of primary care programs and thank you for the opportunity to participate in this important hearing.

Mr. WAXMAN. Thank you very much.

Let me back up and see if I can put this in perspective. The three of you represent pediatrics, family practice and general internal medicine, and feel that you are vulnerable. You are vulnerable in a teaching hospital setting because of biases.

Are the biases the biases of the students in deciding whether to select a residency in your fields?

Is the bias the bias of the hospitals in deciding whether to have residencies in your field?

Or, of course, both?

Dr. ALPERT. Certainly the bias is not within the student. As far as we have been studying---

Mr. WAXMAN. You would reject the argument sometimes made that it is more exciting to be in high technology subspecialties, than to be in pediatrics, family practice or internal medicine?

Dr. ALPERT. In general, yes.

If one looks historically at why students come to medical school, the vast majority come with a role model in mind of caring for patients. That is not to say that high technology and high reimbursement doesn't have its attractiveness.

However, in primary care we do not know when we prevent something in an individual patient. We only know when we fail.

I am amazed that we continue to have the level of excellent applicants for our programs in spite of the issues that we are so concerned about.

No, I don't think the problem is at the level of the students. Now, the student as John mentioned may well be compromised by some of these enormous debts from medical school.

I think unfortunately we can lay the bias in our own institutions. And understandably, as we have said, running the hospital as a business you would not support us because we are not the money-makers.

Mr. WAXMAN. You are not the moneymakers?

Dr. ALPERT. We are not the moneymakers.

Dr. EISENBERG. Let me disagree. I think there is a problem at the student and the resident level. And the reason I say that is because of the cascading effect of decisions down the line of the trainees.

We know from a study from the University of California in San Diego that internal medicine residents make up their mind—most internal medicine residents make up their mind about what they are going to do during their residency. That is one of the reasons they do internal medicine, because it is a sort of pluripotential specialty. And that they make up their mind on the basis of a variety of factors. Certainly one is the potential income. But, one is the role models they are exposed to. And that is not just faculty, but it is the kinds of careers that they see their senior peers entering.

As the primary care programs that have been funded through title VII have provided increasing numbers of faculty who can serve as role models in exciting people who can show that this is an exciting field—and a Nobel laureate once said there is a common misconception that a rare disease is more interesting than a common disease. He pointed out the fact that as a Nobel laureate, he was fascinated by the common cold. It is a combination of allergy and infectious disease and the environment and the home situation. And, he pointed to us as medical educators the challenge to make the common cold an exciting challenge to the trainee.

Now, if there are no faculty who are interested in the common cold, and there are no senior residents who are interested in going into primary care, the medical students will see that, the first-year residents will see that, and their careers, I think, will be shaped in large part by that sort of experience.

Dr. ALPERT. John, I don't think we are in disagreement.

Dr. EISENBERG. I must tell you, when we started our program at Penn in 1975, the first place we went was to Boston City Hospital to a pediatrics program to get some advice. I would never disagree with you, Joel.

Mr. WAXMAN. Do you have any other perspective?

Dr. BOWMAN. I would say a lot of the bias exists in the reimbursement system which, in turn has financial implications at the programmatic level, which in turn affects how medical students view these specialties.

Mr. WAXMAN. So, a medical student is influenced by a role model. But, the medical student has to be influenced by the economic incentives. The economic incentives for the student is to go into a subspecialty, as opposed to one of your three fields. Is that an accurate statement?

Dr. EISENBERG. Yes.

Mr. WAXMAN. The natural incentive for the institution is to have residencies in the subspecialties, because that will bring more money to the institution. Is that an accurate statement?

Dr. ALPERT. That is correct.

Dr. EISENBERG. That is correct.

Dr. BOWMAN. Yes.

Mr. WAXMAN. But, for societal goals, we pay more for subspecialties, residencies and treatment. Even after the residencies they are going to go out and practice medicine where there is going to be a higher cost to everyone who is paying for it, both private and public insurers. And we have a maldistribution of physicians because they are pulled by these incentives.

Now, as society, we as representatives of society here on a broader level, we say we want to change that bias. How do we change the bias? Do we just cut in half the amount that go to medical schools? Is that going to do it?

Dr. ALPERT. Obviously we move in the other direction. We should be increasing not decreasing support. Present programs reach 10 percent of internal medicine programs; 15 percent pediatrics; family practice I think is around 29 percent of those programs presently getting assistance under title VII. At another time we would not be sitting before you hoping that we will hang in there, but rather we would be sitting before you describing a successful program, and we would be asking for, and I suspect you would be responding with additional support. There would be more role models and more influences that encourage students who come to medical school wanting to be a primary care physician.

Some of our students, incidentally, should be subspecialists. Clearly we cannot talk about primary care medicine without the knowledge that there are sufficient number, appropriately distributed, of excellent subspecialty physicians who make it possible for us to develop our emphasis. But it is where, if you will, the majority vote with their careers and their feet.

Another time we would be asking you for more help.

Mr. WAXMAN. If the trend is in Medicare-Medicaid systems reimbursement to change these incentives, how would we do it and would it be strong enough?

Dr. ALPERT. My comment earlier was to put a number and require as one did 8 years ago or 9 years ago, that 50 percent of residency training programs being in primary care disciplines is obviously not enough. Dr. Relman and others are proposing that the number be 70 percent. Perhaps that is enough. I don't know.

What I do know is necessary is some explicit targeting. And I think John sounded the note of collaboration and willingness and ability to work with you to explore what mechanisms there are.

Mr. WAXMAN. You are not thinking of incentives. You are just thinking of our just telling the teaching hospitals what they have to do?

Dr. ALPERT. As national policy in primary care, speaking as an individual, yes.

Dr. EISENBERG. Let me offer a couple of specific ideas that I have had, because I think what we need to do in addition to setting targets, is to facilitate the accomplishments. And by and large what we need to do is help the hospitals and the specialties to redistribute the number of residents that exist.

One way we could do that would be to change the reimbursement system through Medicare-Medicaid so that we don't only pay the surcharge on inpatient care, but we pay a surcharge on ambulatory care as well.

We could do that in the budget in a neutral way. But, why is there indirect medical education subsidy, and passthrough on inpatient care and not on outpatient care. That seems to me to be a disincentive for the kinds of training that we have been describing.

Another way that we might handle it would be to keep the payment on the inpatient side, but to change the formula. The VA, for example, has started moving in the direction of recognizing outpatient volume as well as inpatient volume when it looks at the kind of resources for teaching that each of the VA's is going to get.

Maybe we should do that in Medicare and Medicaid as well.

There are also some known financial barriers. The Residency Review Committees in Internal Medicine have started certifying subspecialty programs with an eye toward improving quality and reducing the numbers of subspecialty programs. They are in the process of doing that, but they are very anxious, as are the residency review committees in other fields, that they will be called to task for antitrust violations. And I think we need some help through the mechanism that might be legislative, to assure them that if they do reduce the number of subspecialty training programs, and thereby the opportunity for medical graduates to be trained in subspecialties, that they won't be in violation of antitrust regulation.

And those are all mechanisms, in addition to setting guidelines. And they would allow, I think, the forces of the free market to take place. But, they would do so in a directed way where we understand that we are trying to push the system, or nudge the system in a certain direction.

Dr. BOWMAN. I would like to add that I think better reimbursement on the outpatient side would help. In some ways it is kind of simple to say and hard to accomplish, and I realize that.

We have had discussions of this within our specialty and, in fact, with the other groups in terms of how this can be accomplished, and I realize it is not simple; but if there is any way we could help you to do that, we would be more than willing. I think improving reimbursement in the outpatient setting would help.

I know in our situation, with Medicaid we get—talking earlier about collection rate. Our collection rate is about one-third of what we charge, and our charges are lower than the average community physician. So I assume they are losing even more on their Medicaid patient. Every Medicaid patient we see we lose money on.

So overall improving the outpatient reimbursement would be a significant help. Overall, I think that capitation systems, which have been becoming an increasingly important aspect of the health care system in the country, likes primary care types of physicians because they are cost effective and work well in that system.

We are not there yet, though. I think that over time the systems, the incentives in the system are going to change, but now is not the time to change the Medicare reimbursements for graduate medical education by halving the indirect cost rate or by getting rid of the title VII policies.

I think that that would be devastating before other changes in the system can occur that might be very beneficial to primary care specialties.

Mr. WAXMAN. Let me see if I can get your reaction to a couple of things. Representatives for the Department said to us their proposal is to cut in half the factor added to teaching hospitals over and above the DRG rate, and that they think it can be absorbed.

As I understand what you are telling me, your reaction to that is that will push things in the direction against pediatrics, family practice and internal medicine, and more toward the profitmaking subspecialty trainings. The AMA position was not to go along with that cutback, if I am characterizing everybody's position correctly, to leave things the way they are, keep the status quo.

If we keep the status quo, is that an acceptable move toward trying to rearrange the incentives on distribution between specialties?

Dr. BOWMAN. I would like to respond, and then my colleagues can. I think that with the prospective payment system increasing the factor under DRG's over the coming years, I think actually that in and of itself is going to hurt primary residency programs.

Mr. WAXMAN. It is going to hurt?

Dr. BOWMAN. It is going to hurt primary care residency programs. If hospitals are squeezed, where are they going to cut? They are going to potentially cut some graduate medical education positions, which was a point made earlier. Which positions are you most likely to cut? You are most likely to cut those that lose you dollars, and that is primary care.

Therefore, I think the prospective payment system itself is sufficient to harm the primary care field, and status quo is actually not enough.

Mr. WAXMAN. Would you both agree with that?

Dr. EISENBERG. I agree, but let me mention a factor that has not come up, which is the severity scale issue. The way the DRG system is currently set up, there are clear incentives, because of the procedural increase in payment for surgery that induce hospitals that want to increase their surgical rate if they can and thereby the number of assistants they have, or are often residents.

On the medical side, where we are often taking care of patients who have complex, multisystem disease, we find you can get credit for one extra disease on the DRG system but only for one extra disease, usually, and there are clear disincentives given this current situation.

Even disregarding the issue of whether it is 11.59 percent or half of that, that the current system is biased against training in the medical specialties and toward the surgical specialties.

Dr. ALPERT. The application of DRG's in the general hospital for pediatric care as presently constituted will be a disaster for us because they simply will not take into consideration the fact that we—and I am being much too simple—spend most of our time listening and attempting to intervene around complex social problems.

I myself am glad I don't have the responsibility for developing a DRG that takes that into consideration.

Mr. WAXMAN. So you think the DRG system works to your disadvantage. Do you think if we squeeze down too much on that extra factor for a teaching hospital over and above the DRG rate, that works to our disadvantage? And therefore, it seems to me what you

are saying is the only way we can change the situation is to be more aggressive in reimbursement changes that try to work more toward recognizing the financial disincentives in compensating for the work you do.

Dr. ALPERT. Were it not for the meat cleaver that was hanging there, I suspect in a happier time that is what we would be talking about.

Mr. WAXMAN. Unless we do that, if we go along with the teaching hospitals and just continue to give them the extra money, that factor over and above what they are getting in the DRG rate, we are really dependent on a trickle down. If there is just more money, then maybe more will trickle down to you. If there is less, none will trickle down to you, but you are really at the bottom.

Dr. ALPERT. That is correct.

Mr. WAXMAN. Mr. Nielson.

Mr. NIELSON. Thank you.

Dr. Eisenberg, I am sorry I didn't hear your whole testimony, but why do you think specialists are paid so much more than primary care physicians?

Dr. EISENBERG. It is obviously a very complex issue. There are a variety of reasons. One of them is the way in which we set prices in most third-party payment systems in this country, with the usual, customary and reasonable rate.

Those rates are often set when the first providers in that specialty provide that particular service. Maybe it is a coronary artery bypass graft or maybe it is a particular kind of endoscopy. It is very difficult when it is new. Few people can do it and it takes a lot of time. So those people charge a lot of money for it.

That price gets set and that price becomes the standard price for that procedure or for that operation. It is very seldom that we decrease the amount that we pay for those services, and that is one of the main reasons why the procedure-rich specialties end up being paid more, if we were to look at it on the basis of effort, resources consumed, time consumed, for example, than do the primary care specialties.

Let me just finish with a second reason. To pick up on what Dr. Alpert said, it is difficult to document intangible services that are provided to patients, particularly counseling, preventive services, and just sitting and talking about how the person is feeling and what their family is doing. It is much less well reimbursed than are those other procedures, and I think it is a variety of factors. Those are two of the most important.

Mr. NIELSON. Economics 101 notwithstanding, law of supply and demand ought to work, oughtn't it? Dr. Bowman suggests that you have an oversupply of specialists and you are short in family physicians. Should not that oversupply bring the prices more even?

Dr. EISENBERG. Mr. Nielson, I usually don't admit it, but I have an M.B.A. which I got after my M.D., and one of the things I learned there is that the United States doesn't really have a free market in the health care sector which operates by standard rules of supply and demand; that there is, in fact, the phenomenon of induced demand, whereby physicians might decide that they have a certain target income or that they have a certain number of procedures that they want to provide for any of a variety of reasons.

Because of the fact that patients are not fully informed consumers as we are when we buy certain other products, the doctor often has more discretion than other providers do. I think that the vast majority of physicians in this country act as their patients' agent, but there are a lot of tossups in medical care. There are a lot of decisions that are on the line.

Mr. NIELSON. Would you agree with Dr. Bowman that specialties are oversupplied relative to family care physicians?

Dr. EISENBERG. I agree with that.

Mr. NIELSON. Shouldn't that be self correcting at some point?

Dr. EISENBERG. One of the results—

Mr. NIELSON. I am just saying, is anything going to work to alleviate this maladjustment or malapportionment.

Dr. EISENBERG. By sheer mass effect, I think there will be some changes. It is a bit like a flood and a dike. There is a tiny hole in that dike. There are going to be some of those people who would have been subspecialists trickling through that hole and becoming generalists, but there has to be a tremendous oversupply on the other side of people who are inducing demand for their procedures, I think, before that effect is going to occur.

A second phenomenon occurs, which is that those specialists, surgeons, ophthalmologists, whatever you choose to look at, are going to be providing some primary care services. One of the considerations that the Congress is going to have to make is whether or not we want to have a reimbursement system which encourages physicians to go into those specialties but then doesn't allow them to practice that specialty because of the competition that you are describing once they get into it, so they turn to a practice that they were, we think, inadequately trained for.

Mr. NIELSON. I would like to ask Dr. Alpert. This morning we had the AMA suggest that they had supported the concept of DRG initially and still felt it was the right way to go, except that they didn't want the cutting from 11 down to 5.89.5

Did you as an individual or your group support the DRG system initially?

Dr. ALPERT. DRG's were developed at Yale, and although I am a Yale undergraduate, and not for the purpose they are now being used. At the point that I became aware as an individual of DRG's, I was aware of them in the climate of the way they were being constructed and written and not be applied. They present enormous difficulties for child advocates, pediatricians and for primary care in general.

I have had no experience with it in Massachusetts because we have been a waiver State.

Mr. NIELSON. Why do you suppose the AMA and the Hospital Association supported the change if there are all these difficulties?

Dr. ALPERT. While I would never speak for the AMA or the Hospital Association—

Mr. NIELSON. They spoke for themselves.

Dr. ALPERT. I guess like most things in life, if something is coming down the road and it is coming, you maybe have to negotiate it and accept change, and I think that escalating hospital costs are a major issue and I think hospitals can be run more effectively and more efficiently.

Mr. NIELSON. Dr. Bowman, you quoted two studies in your testimony. You found the average family practice residency generates about 20 percent of the total program cost to your patient care revenues, about 20 percent. How would that compare with specialists, other fields, medical?

Dr. BOWMAN. I wish I had the exact figures for you. Somebody may. But I would say that there are some that say 80 percent in some of the subspecialties, and overall, over half comes from patient care revenues.

Mr. NIELSON. What types of family practices have been funded through the Title VII Public Health Service funds?

Dr. BOWMAN. Excuse me?

Mr. NIELSON. What types of public family practice projects have been funded through title VII Public Health Service funds?

Dr. BOWMAN. Several types of projects. Family practice residencies specifically receive training dollars. Predoctoral training in family medicine where medical schools receive money to help train undergraduate or medical school level students in family medicine. Faculty development in family medicine to trainers to teach residents and students. And the fourth area has been departments of family medicine, where money has gone to help strengthen departments in medical schools.

Mr. NIELSON. Do you feel we don't need Title VII anymore? Do you feel we now have enough physicians in the short run and in the long run? You feel title VII is no longer needed?

Dr. BOWMAN. I think the two are not tied. Perhaps we do have enough physicians already and are going to have too many soon, but I think title VII is about what type of physician that we have.

Mr. NIELSON. How shall we change title VII so more of them go into family practice since the law of supply and demand, Dr. Eisenberg thinks, doesn't work? So how can we change title VII to get the emphasis where it needs to be?

Dr. BOWMAN. I think having training dollars is extremely important. I would actually urge that we have more training dollars than we had and we use—

Mr. NIELSON. That isn't an option this year.

Dr. BOWMAN. I'm trying.

Mr. NIELSON. What I am trying to get you to say—we do have a plan which would fix Title VII in such a way that the money we do have, which is in short supply, would go to the area which needs it most and stop putting it where we don't need it, where we have an oversupply.

Now, if you can come up with some idea, I think the chairman would also go along with it.

Dr. BOWMAN. We would be more than willing to submit a short plan on how to help do that.

Mr. NIELSON. I appreciate that.

You say family practice residencies do not fit the traditional graduate medical education mode.

Dr. BOWMAN. That is correct.

Mr. NIELSON. How and why do family residents differ?

Dr. BOWMAN. The training differs significantly in having increased emphasis on an ambulatory setting, and preventive services, in learning how to take care of an entire family. I think the

training often emphasizes more type of social issues, which in turn impact the patient's health more than traditional graduate medical education.

I think that training is appropriate to the types of settings in which family physicians will be practicing in the long run, which provides greater quality care.

Mr. NIELSON. Do you think there is sufficient training in the hands-on experience in the outpatient program rather than the in-patient?

Dr. BOWMAN. In family practice residencies I do.

Mr. NIELSON. You think there is plenty there?

Dr. BOWMAN. Yes.

Mr. NIELSON. How about medical schools in general?

Dr. BOWMAN. No.

Mr. NIELSON. How would you change the medical schools so that they get more emphasis there?

Dr. BOWMAN. That is a tough one. There certainly are essentials that medical schools must meet in order to be accredited. If those essentials were somehow different, I think that would help.

I also strongly believe the financial incentives, that things get molded partially by the financial incentives that occur, and that, in the long run, would also make a difference.

Mr. NIELSON. I have no further questions. I would compliment the panel and thank the chairman.

Mr. WAXMAN. Thank you very much.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

My apologies, sir, and to the panel for not having heard their testimony. I made the mistake of going back to my office after lunch.

Dr. Bowman, I guess, and Dr. Eisenberg, particularly on this question of family practice, you made the comment, Dr. Bowman, I believe, just a moment ago that you feel the training for family residencies is adequate under the present scope?

Dr. BOWMAN. Yes. Currently the way the family practice residencies are structured, residents are required to have essentially 25 percent of their entire time in a continuity family practice center. In addition—

Mr. BILIRAKIS. What is a continuity family practice center?

Dr. BOWMAN. The family practice center is where residents learn an essentially private practice model. They have patients that are their own patients that they follow over the entire period of their residency that are supervised by faculty in that setting to do so. They follow those patients that are admitted to the hospital. If they go to a nursing home, they provide the care for that patient.

In addition, in family practice residencies there are other outpatient types of experiences that are required, such as in dermatology, ophthalmology, ENT, gynecology.

Mr. BILIRAKIS. You feel, then, that there is adequate outpatient experience that is required of these residents?

Dr. BOWMAN. Yes, in family practice residencies, as I said.

Mr. BILIRAKIS. Earlier—I suppose you were in the audience—we talked about the possibility of exploring changes in the reimbursement methods so that outpatient revenues could pay for this train-

ing so that we could then encourage primary care residents to go into outpatient practice.

Do you not think that that is necessary, then?

Dr. BOWMAN. I think there is currently adequate training in outpatient settings for family practice residents. However, I think that some of the changes that are occurring with the prospective payment system is going to put a crunch on that and on residencies, and we have lost some residencies over the financing issue and we may be losing more, and the changes that have been proposed would be, I think, so involved.

Mr. BILIRAKIS. So you would recommend to us that we, in fact, all look at the reimbursement picture so that we could encourage—

Dr. BOWMAN. Absolutely.

Mr. BILIRAKIS. I am glad to hear you say that.

Well, Dr. Eisenberg, going back to the point—I guess I wasn't really trying to make a point; I was trying to learn, and I think all three of you are too young to go back to prior to 1965 on what training—no, you have no grey hair.

In any case, based on your actual experience and based on your knowledge of what may have taken place back in those days, who did the teaching hospitals treat in those days as against whom they are treating today? What type patients? And who were they not treating then that are being treated now?

Dr. EISENBERG. Let me address that in two ways because I have read about it.

And Joel told me about it once.

I think there are really two answers to that. One of them is that teaching hospitals were very different before 1965, in that in most teaching hospitals there were two classes of care. There were the ward patients and then there were the private patients.

The ward patients were those patients who were cared for without as much supervision as all patients currently have today. They were cared for in different units. They certainly didn't have the amenities, and some might have argued they didn't have as high quality of care as the other patients did.

Since 1965, almost all teaching hospitals have moved towards and have accomplished one class of care, which I think is a tremendous salute to Medicare and Medicaid because it has enabled teaching hospitals to provide equal care to all people, and that is one major difference.

A second difference is that there were far more hospitals that were funded by municipalities or States, and we used those teaching hospitals at that time. The one that Dr. Alpert represents, Boston City Hospital, has survived the one in which I was trained. What was Philadelphia General Hospital is now a parking lot.

For better or worse, we don't have as many city hospitals as we used to. The city hospitals are not providing the training that they did before, and I think in some ways those hospitals provided two-class care, although I know many of the city hospitals have overcome that obstacle as well.

Those are two ways in which things have changed since then.

Mr. BILIRAKIS. All right.

Now, not in any way meaning to belittle the significance of treating the poor—just don't accept it that way because I don't mean it that way—but if we were for the moment to set that aside, do you feel that the quality—now, I know there have been medical advances and whatnot, but do you feel that the quality of teaching the medical students in the teaching hospitals has been greatly enhanced as a result of the Federal dollar reimbursement?

In other words, weren't doctors being trained adequately in those days?

Dr. EISENBERG. I think in some ways doctors were trained better in those days, and one of the spinoffs of the past 20 years has been an increasing number of doctors who are superb at what they do but whose focus is somewhat narrower than the trainee's need. That, in fact, is one of the major agendas for the American College of Physicians and for the Primary Care Society in Internal Medicine, which is to redress that deficiency of general internist faculty who can teach the whole patient and address issues other than those that are narrow, limited to an organ system or mechanism of disease.

I think just as Federal funding was responsible for the problem, that Federal funding might be responsible for the solution. That is why I came today.

Mr. BILIRAKIS. That is interesting. Thank you very much.

Yes, Doctor? I didn't mean to slight you.

Dr. ALPERT. I would use the word differently, not better.

I would also say that what was done for its time was all right. Since the specialization phenomenon is post-World War II and it is not a 1965 phenomenon. It began at celebrated institutions like Boston City, which has a distinguished scholarly tradition as well as a tradition of serving those less advantaged. What was done was very good for the time.

What was done in 1964—and I have been at Boston City 14 years and I have been in pediatrics 29 years now—would, however, simply be unacceptable by today's standards, and we would consider it exploiting the patients who came to us for care and for service. But it was right for the time and is wrong today.

It was terribly wrong when it was happening, and this is perhaps for another forum, that after having made the extraordinary gains that entitlement provided through Medicaid and Medicare—and through Medicaid I will speak to the increased access of disadvantaged children in receiving health services, so our immunization rates went up, our access to services went up, sources of care went up, the way in which residents and students are being treated and are being educated today is revolutionary compared to what went on in medical schools 20 and 25 years ago the way I was educated—what we are seeing now is a slippage, and a slippage back toward a two-class system.

Mr. BILIRAKIS. Are you saying if this takes place there will be a slippage, or are you actually seeing it now?

Dr. ALPERT. There is a slippage now.

Mr. BILIRAKIS. Even with the additional funds that took place—when was it, 1983, whatever?

Dr. ALPERT. Absolutely. 47 percent of the patients who come to Boston City Hospital presently represent uncompensated care. The

institution's buildings are 50 and 60 years old, and in the next 18 months we may find out whether we will be joining Philadelphia General or not, and I certainly hope the outcome is quite different.

If what we heard this morning from the administration takes place, it will only hurry up the process of closing institutes like BCH.

Mr. BILIRAKIS. I gather from what you are saying, then—and, you know, I think I have as much compassion as the other guy even though I am a Republican——

I say, is throwing money at a problem always the solution? I ask that question. So basically I think what you are saying to me is that in spite of all the money that has been forthcoming to the teaching hospitals since the midsixties, that there still is a slippage and so money has not necessarily been the answer.

Dr. ALPERT. Oh, no. What I said was the fact of money, whether it be in the educational programs in this regard, the support of the primary care specialties, or the money, whether it is given through Medicaid to those who are less advantaged, has made an enormous difference. I am sorry to say the slippage has occurred as the reimbursements have become more painful and more difficult.

I work and live in a resource-rich State, and we have in our State, for example, had to replace Federal nutrition funds. We have a legislature that was in a position to do that. These funds were taken away by decisions made at the Federal level. The slippage has occurred in the last year and a half to two, and I have data which is very troublesome to me, that shows that infant mortality rates are going up in selected census tracts, those are census tracts where women are getting fewer prenatal services, where our percentages of low birth rate, premature infants are going up.

In other words, it has been the process of removal of reimbursements on the service side which has caused the slippage back. What was done and started in 1965, I can't say it was done necessarily the best or that every 100 cents was a dollar returned, but it worked and things are a lot better.

I guess my plea today on the educational side is not to let that slippage——

Mr. WAXMAN. Will the gentleman yield?

Mr. BILIRAKIS. Yes.

Mr. WAXMAN. Let me see if I understand what you are saying. The slippage you see is because there are fewer dollars under the present reimbursement system? Or is it because you have so many patients for which there is no reimbursement at all?

Dr. ALPERT. It is both.

Mr. WAXMAN. What was the percentage of uncompensated cases that you have?

Dr. ALPERT. Forty-seven percent. Almost all of those are adults, in a category called general relief.

Mr. WAXMAN. So 47 percent of your patient population you are seeing, you are not getting Medicare, you are not getting Medicaid, they don't have private insurance?

Dr. ALPERT. Correct.

Mr. WAXMAN. But they are not able to go anywhere else and you don't turn them away?

Dr. ALPERT. That is correct.

Mr. WAXMAN. So, in effect you have got to hope that the Medicare reimbursements, the Medicaid reimbursements or the private insurance reimbursements will be sufficient not only to take care of the patients for whom those reimbursements came but for everybody else that you see, and that includes almost half of all the patients you see. So you have got to have half the patients you see take care of the cost for 100 percent.

Dr. ALPERT. That is correct. And the reason we are still opening and operating is because of the waiver, which in Massachusetts allowed free care to become reimbursable under Medicaid and Medicare and meant \$37 million more to the hospital out of an operating budget of \$106 to \$108 million.

Mr. BILIRAKIS. This is outside the scope, I suppose, because it is not a teaching hospital, but we have a hospital in Tampa, FL, which—I don't know that it was the only hospital that took in indigent care patients, but I would say a very large amount of theirs, certainly the majority, were indigent care, and they just about closed their doors. They just couldn't handle it anymore.

Now I am advised they have gone to the other extreme. They won't take any indigents at all because they want to remain alive. So I guess we have got to be careful of extremes here. I think basically what you are saying is that before 1965 we had—you call it different—we had one type of care, and then as a result of Federal funding, we were able to improve that care to such an extent that now, with any reductions, with some reductions, we are talking about slippage to the improved care that we have become accustomed to.

Dr. ALPERT. That is correct, from the improved care on the service side because we are going back to a two-class system. On the educational side, in our positions here today, as Mr. Nielson said, we are not being logical the way we would like to be logical and asking you for more assistance. We are basically trying to stay even.

Dr. EISENBERG. I think we are also asking for a redirection. Even if the money were the same, we think it can be targeted, so we wouldn't be throwing money per se.

Mr. BILIRAKIS. Have you given us any suggestions on redirection?

Dr. EISENBERG. I mentioned a couple several minutes ago. The idea of taking money which would—the idea of addressing the problem of ambulatory care education not having a surcharge attached to it while inpatient care does, does not mean that we have to add an ambulatory care surcharge on top of an inpatient surcharge or subsidy for education. It could be that the same amount as we currently are allocating could be redistributed.

In fact, if we believe the 22,000 residency slots we have are more than we need for the 17,000 graduates of accredited medical schools in the United States, it may be that there are 5,000 residency positions that we don't need. Maybe we want to keep those and maybe we don't, but there is a place where some of the funding could come from.

Mr. BILIRAKIS. If we were to eliminate those 5,000 or a portion of the 5,000, let's say, if it were within our scope, all of us, to do, would care of the indigent suffer?

Dr. EISENBERG. I think care of the indigent would suffer because presently we use residents as cheap labor in many inner city hospitals. Those hospitals attract residents who are not as competitive, who are attracted to the residency programs. Why do they? Because the residents need to go someplace—except for Boston City Hospital. I heard a gasp.

He is still sitting in his chair.

Some of those hospitals attract residents who are not as competitive for other places. Why? Because the hospitals don't have the teaching facilities, because the quality of care may not be as high, so they attract cheap labor, they attract residents. The reason foreign medical graduates go to those hospitals is because the American medical graduates—

Mr. BILIRAKIS. I think it is within our purview—all of ours, the AMA and us—in the profession to do something about that without necessarily saying, hey, let's have an additional 5,000 residencies for foreign medical school doctors in order to take care—I can see there is a bigger need.

I mean to go to the University of Florida in Gainesville for a residency is probably great. They are probably up in the upper plateau in terms of the interest on the part of the residents, and maybe to go to downtown Chicago would not be, but that is something we should do something about. After all, we have taxpayers' dollars involved in helping to train these people; by gosh, we ought to pull the ropes. That is my feeling, anyhow.

But thank you. I appreciate your testimony very much.

Mr. WAXMAN. Thank you very much. This has been an excellent testimony for us.

We are now being summoned to the House floor to respond to a vote. Why don't we recess now just as long as it will take us to get over there to vote and come right back. We are going to try to do that in 5 to 10 minutes.

[Brief recess.]

Mr. WAXMAN. For our next panel I would like to call forward Sheldon King, executive vice president and director of Stanford University Hospital; Robert Sillen, administrator, Santa Clara Valley Medical Center; Dr. William F. Minogue, president of the Association for Hospitals, vice president, medical affairs, Overlook Hospital.

I would like to welcome you to the subcommittee this afternoon. I appreciate your patience in waiting as we have taken the time to respond to votes and to hear from other witnesses. We are looking forward to your testimony. Your prepared statements will be made part of the record in full.

We would like you to summarize your testimony in around five minutes, if that is possible.

Mr. King.

STATEMENTS OF SHELDON S. KING, ON BEHALF OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES; ROBERT SILLEN, BOARD MEMBER, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS; AND WILLIAM F. MINOGUE, M.D., PRESIDENT, ASSOCIATION OF HOSPITAL MEDICAL EDUCATION

Mr. KING. Good afternoon. I am Sheldon King. I am chairman of the Council of Teaching Hospitals this year.

The Association of American Medical Colleges welcomes the opportunity to testify at this hearing on Federal funding of graduate medical education. Our present system for graduate medical education, or GME and its financing, has much to commend it.

Nevertheless, GME rests upon a relatively fragile interweaving of multiple institutional capabilities, individual goals, foregone compensation, and personal initiative. It is a system that could be damaged easily unless any changes to it are crafted carefully and based on an extensive understanding of both the nature of the teaching hospitals in which GME is carried out, and the nature of graduate medical education itself.

My written statement which you have contains significant background information on the present financing of GME and problems we see developing in the price competitive environment. We have also attached papers on Medicare's so-called indirect medical education adjustment by Judith Lave and we would like to call to your attention pages 4 to 6, and the statement of issues on GME financing by the AAMC Committee on Financing Graduate Medical Education. In the interest of time, I won't review any of those items.

Turning to the administration's proposals, we see once again this year the Federal budget process is being used to propose major changes in the Medicare system for paying for in-patient care. Three of their proposals are of significant concern to teaching hospitals:

One, the proposed freeze in the hospital-specific, regional and urban prices used to determine DRG payments; two, the proposed 50 percent reduction in the so-called indirect medical education adjustment, which is really a surrogate for added service costs or severity of illness; and three, the proposed freeze in payments for direct medical education costs.

Each of these proposed changes would result in a substantial reduction in Medicare revenues for teaching hospitals. Collectively the three proposals would result in an unparalleled reduction in Medicare revenues. Because of the subject of this hearing, I will comment primarily on the last two proposals.

The Congressional Budget Office estimates that the permanent freeze on direct medical education and halving the resident-to-bed adjustment amount to \$720 million of the President's proposed \$2.3 billion reduction in Medicare's hospital spending. That would mean the teaching hospitals were being asked to absorb 31 percent of Medicare's reduction in hospital payments.

Teaching hospitals are multiproduct enterprises. In addition to patient care services, they provide clinical training programs for graduate medical, nursing, and allied health education. Since its inception, Medicare has supported its fair share of those program costs. Reducing Medicare support will weaken these manpower de-

velopment programs. It will also set a precedent which other payers may cite as the basis for reducing their support. Rather than having deficit reduction politics determine future health manpower policy, the AAMC recommends strongly that public policy on financing graduate medical education be debated fully and resolved prior to altering the current passthrough.

Therefore, the Association of American Medical Colleges is opposed strongly to any change or reduction in the passthrough for direct medical education costs until a comprehensive assessment of financing graduate medical education is completed and considered fully.

In terms of the resident-to-bed or indirect medical education adjustment was originally developed to create a level playing field for teaching and nonteaching hospitals under prospective payment. Unfortunately, old and often incorrect data on resident numbers, bed complement, wage rates, and DRG case mix were used in estimating the adjustment.

In addition, two variables not included in the final payment system, bed size and urban area size, were included in the formula used to compute the adjustment. The resident-to-bed adjustment is a crucial equity factor in prospective payment.

It should be retained, but it should be estimated properly. An unbiased and more defensible adjustment can be obtained if the adjustment is reestimated with an equation based only on the factors used in prospective payment to vary DRG prices and with up-to-date, accurate data.

Therefore, the Association of American Medical Colleges supports recomputing the resident-to-bed adjustment, using current hospital resident and bed data, up-to-date corrected hospital case mix indices, corrected wage indices, and a regression equation which incorporates only variables used in determining hospital DRG payments.

For price blending, it is clear that as the hospital-specific component of DRG price decreases, weaknesses in the design of the system are becoming more obvious. The continuing move to using only the national average price to make payments will reveal further weaknesses and make the accuracy of the resident-to-bed adjustment more crucial.

As a result, some hospitals will be rewarded economically because of favorable circumstances outside of management's control; others will be penalized financially for unfavorable circumstances beyond the hospital's control, such as a sicker mix of patients within the DRG's.

If Congress is unwilling at this time to adopt a long-range solution, such as DRG-specific blending, an interim approach that would moderate both windfalls and catastrophes for the teaching hospitals would be to set payments based on a blend of hospital-specific and average prices.

The Association of American Medical Colleges recommends that Congress amend the DRG price formula so that it is based on a blend of 50 percent hospital-specific costs and 50 percent of regional average costs.

Finally, it is clear that many of the discussions about the future financing of graduate medical education have been stimulated by

Federal budgetary considerations. Numerous proposals have been outlined or rumored. This state of affairs is detrimental to graduate medical education. Strong residency programs require years of effort to build. They require continuity of effort and stable support. Instability is harmful. The costs of GME training are real. If the programs are to continue, the costs cannot be avoided.

Therefore, the AAMC calls upon public policymakers from all perspectives to acknowledge that the present debate should not be about paying or not paying these costs. The debate should be about the most appropriate method of supporting graduate medical education.

[Testimony resumes on p. 411.]

[The prepared statement and attachments of Mr. King follow:]

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Financing Graduate Medical Education

Presented to the Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives

by

Sheldon S. King
Executive Vice President and Director
Stanford University Hospital

April 3, 1985

Association of American Medical Colleges / One Dupont Circle, N.W. / Washington, D.C. 20036 / (202) 828-0490

The Association of American Medical Colleges welcomes the opportunity to testify at this hearing on Federal funding of graduate medical education. The AAMC, which represents all of the nation's medical schools, 73 academic societies, and over 350 major teaching hospitals participating in the Medicare program, is vitally interested in all aspects of medical education in the United States. If future generations of Americans are to have appropriate access to well-trained physicians, we must continue to maintain and strengthen our medical education system, including its residency training component. Moreover, we must maintain the capabilities and strengths of our system in the face of dramatic changes in the environment faced by teaching hospitals, medical schools and clinical faculty.

Our present system for graduate (GME) medical education and its financing has much to commend it. Nevertheless GME rests upon a relatively fragile interweaving of multiple institutional capabilities, individual goals, foregone compensation, and personal initiative. It is a system that could be easily damaged unless any changes to it are carefully crafted and based on an extensive understanding of both the nature of the teaching hospitals in which GME is carried out and the nature of graduate medical education itself.

Contemporary American teaching hospitals are among our nation's most complex enterprises. In addition to the basic hospital services of primary and secondary inpatient care, teaching hospitals provide the bulk of the nation's tertiary care for the most seriously ill; regionalized special care and stand-by services; clinical training of physicians and other health care personnel; access to medical services for disproportional numbers of the poor and medically indigent; and the development and testing of new diagnostic and treatment

services. Significantly, these multiple products are not independently provided in separate corporate divisions. Rather, the teaching hospital's added responsibilities are generally fulfilled in a single organization with multiple, interrelated objectives. While this hearing considers only one of the special responsibilities of teaching hospitals--graduate medical education--the AAMC must note that the future of teaching/tertiary care hospitals rests on adequate societal support of all these specialized functions.

Contemporary Graduate Medical Education

Graduate medical education is the phase of formal medical education that begins at graduation from medical school and ends after the educational requirements for one of the medical specialty certifying boards have been completed. The term "residency" is commonly used to describe that period of graduate medical education.

Graduate medical education has become as important as undergraduate medical education in the preparation of physicians. It has evolved from a short period of practical experience in a hospital into a formalized, structured educational program, the completion of which is necessary for physicians to be capable of practicing medicine at a level consistent with current knowledge and technology and anticipated developments. In the 1980s, over 16,000 students will graduate annually from the 127 medical schools accredited by the Liaison Committee on Medical Education. The vast majority will spend three to seven years as residents in graduate medical education.

As reported in the current issue of the Directory of Residency Training Programs, there were 74,495 residents in GME on September 1, 1984. This training was provided in a total of 1,554 institutions, the vast majority of which were hospitals. While simple division would suggest an average of 48 residents per

training institution, this is misleading. The 100 non-Federal AAMC member hospitals with the largest residency programs were providing training for 46% of the total residency complement. Thus, while a large number of hospitals (and some other agencies) are involved in residency training, less than two percent of all hospitals provide training for nearly one-half of all residents.

The Directory of Residency Training Programs presently lists accredited residency programs in 40 specialties. The Directory's tabulation shows, however, that 60% of all residents are training in five fields of specialization: internal medicine (24.4%), general surgery (11.0%), family practice (9.9%), pediatrics (8.1%), and obstetrics/gynecology (6.2%). These are the specialties that most Americans use for primary medical and surgical care.

It should also be noted that 55% of residency training takes place in eight states: New York, California, Pennsylvania, Texas, Illinois, Ohio, Massachusetts, and Michigan. While this may appear at first to be a very high percentage, these states contain 47% of the population according to the 1980 census.

The key conclusion from a review of residency program size, concentration of specialties, and location of training is clear: while the majority of residents are concentrated in a small number of hospitals, specialties, and states, the remaining residents are widely distributed. With this heavy concentration but broad dispersion, public policy makers must carefully consider the impact of proposed policies on both the heavy concentrations as well as the broader distribution.

Under the present system of graduate medical education, residency training is financed primarily by patient service revenues, most particularly by payments of hospital charges and reimbursement. For example, data from the AAMC's 1984

survey of stipends paid to housestaff, show 81% of the stipends are paid from hospital patient revenue when Federal hospitals are excluded. The next largest source, state appropriations, supports only 5% of residents' stipends. For advanced residents, called clinical fellows, the role of hospital revenues is somewhat smaller, but still accounts for over 61% of funding. While residents' stipends are only one major cost of these programs, the AAMC believes the importance of hospital revenue is characteristic of the total costs as well.

The data presented on residency financing excludes Federal hospitals, both Veterans Administration and military. A significant number of residents train in these hospitals, with the VA alone providing training for approximately 10% of all residents. Funds for these residents are provided to VA and military hospitals as a part of their Federal appropriation.

In addition, a limited amount of Federal support for residency training in general internal medicine and pediatrics and family practice is available from the Public Health Service. In FY 1983, \$45 million was appropriated for these grants. For FY 1986, the President's budget proposes to eliminate this support. A number of states also provide special funding for family practice residencies. Thus, Federal and state appropriations provide only a highly limited and potentially diminishing source of funding for GME.

To obtain the necessary revenues, non-Federal teaching hospitals include residency program expenses in setting charges and determining reimbursable costs. The present Medicare program presents an excellent example of how this practice works to support graduate medical, nursing, and allied health education.

Medicare PaymentsDirect Medical Education Costs

To provide clinical training for residents, nurses, and allied health personnel, hospitals incur costs beyond those necessary for patient care. Since its inception, Medicare has paid its share of these added direct expenses on a cost reimbursement basis. Under prospective payment, cost reimbursement for these expenses is continued using the "direct medical education passthrough."

The justification for this passthrough was clearly described in the Secretary's 1982 report Hospital Prospective Payment for Medicare (pp 47-48):

The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.

Congress supported the Department's position that it was not appropriate to include clinical training costs in the DRG payment and approved continuing to pay the added costs of graduate medical education on a cost reimbursement basis separate from the DRG based per case payment.

Medicare's share of the direct medical education passthrough is determined using generally accepted accounting principles and Medicare reimbursement regulations. The hospital accounting system accumulates expenses directly associated with these activities in specific cost centers. For example, hospital expenses for resident stipends are recorded in the graduate medical education (or intern and resident) cost center. After all expenses are entered, overhead expenses -- such as administration, maintenance, and utilities -- are allocated

(or apportioned) across the Medicare recognized cost centers such as graduate medical education. Thus, the cost being reimbursed through the direct medical education payment includes expenses incurred by that cost center and allocated overhead.

"Indirect Medical Education" Adjustment

In the Secretary's report on Hospital Prospective Payment for Medicare, DHHS proposed an adjustment in DRG payment rates based on the ratio of residents-to-beds in teaching hospitals. As Congressional committees considered the proposed Medicare prospective payment system early in 1983, the Congressional Budget Office (CBO) prepared estimates of the impact of the new payment system including the resident-to-bed adjustment on different types of hospitals. Hospitals were compared on the basis of region, urban/rural location, bed size, ownership and teaching status. CBO estimates showed that teaching hospitals would suffer disproportionate revenue losses under the proposal and that the amount of the loss would be relatively greater for hospitals with at least .25 residents per bed than for hospitals with lower resident-to-bed ratios. Because the Department's proposed adjustment did not provide equitable treatment for tertiary care/teaching hospitals, Congressional committees asked CBO staff to estimate prospective payment impacts using a doubling of the Department's proposed adjustment. The resulting estimates showed teaching hospitals would be benefited or penalized under the new sytem in approximately the same proportion as non-teaching hospitals. Thus, a doubling of the proposed resident-to-bed adjustment provided the desired equity between teaching and non-teaching hospitals.

Congress clearly recognized the multiple deficiencies the adjustment would help correct.

This adjustment is provided in the light of doubts ... About the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents ... The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (Senate Report 98-23, p. 52)

In the AAMC's judgment, the resident-to-bed ratio serves as a proxy to adjust for inadequacies in prospective payment, including:

- o inadequate recognition of differences within a DRG of the complexity of disease, intensity of care required and resources utilized for patients in the teaching hospitals;
- o no recognition for the teaching hospital's costs of maintaining both a broader scope of services and the capacity to provide specialized regional services;
- o failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas;
- o decreased productivity which results from including trainees in the hospital programs; and
- o additional ancillary services ordered by trainees involved in the diagnosis and treatment of patients.

Thus, while the resident-to-bed adjustment is called the "indirect adjustment for costs accompanying medical education," it is, in fact, a proxy measure to provide

appropriate compensation for the added patient service costs borne by teaching hospitals. Nevertheless, its "medical education" label permits the adjustment to be viewed as an educational payment rather than a correction for statistically consistent differences in cost between teaching and non-teaching hospitals. The AAMC is concerned about this misperception and commissioned HCFA's former research director, Judith Lave, Ph.D., to prepare an objective review of the historical development of the adjustment and to recommend improvements in the Prospective Payment System. Copies of Dr. Lave's paper are attached.

Vulnerabilities and Benefits

Medicare's participation in the financing of graduate medical education faces several challenges. First, to preserve budget neutrality, any special funding for the multiple missions of teaching hospitals reduces the general patient care payment rate for all hospitals, both non-teaching and teaching. Since most hospitals are non-teaching, some do not support this reduction in the general payment rate. Secondly, teaching hospitals vary in the intensity of their medical education activities. Teaching hospitals with small residency programs have less at stake than teaching hospitals with major programs. Lastly as Congress considers options to reduce the deficit, payments identified with medical education may be more vulnerable than payments for patient care.

Because of these vulnerabilities, two benefits of the present Medicare system should be acknowledged. First, Medicare regulations define residents caring for inpatients as a hospital cost. Therefore, residents are not allowed to bill Medicare on a fee basis for professional services. This is a major savings in Medicare Part B expenditures. For example, in the Tax Equity and Fiscal Responsibility Act of 1982, Congress incorporated in statute the long-standing practice in most teaching hospitals that Medicare patients could

not be charged an assistants-at-surgery fee when a resident is involved in the case unless certain exceptions were met. Similarly, residents performing histories and physicals or administering treatments are not allowed to bill for these services. Thus, while Part A costs are increased to fund residents and their training programs, Part B costs are reduced.

Secondly, while the Medicare program serves primarily today's senior citizens and the disabled, it is financed primarily by taxes paid by the employed. Since Medicare's participation in financing graduate medical education helps to ensure that tomorrow's retiree is served by a fully trained physician, GME dollars spent today serve both today's beneficiary and tomorrow's retirees.

Teaching Hospital Finances

While teaching hospitals have greater expenses per admission than non-teaching hospitals, additional products are produced: medical, nursing, and allied health student are trained; new technologies are introduced; and complex patient services are provided. Historically, these added costs have been financed primarily with increased charges and reimbursement using several types of cost shifting:

- o patient service revenues have supported graduate medical education,
- o routine service revenues have supported tertiary care patients,
- o revenues from high volume ancillary services have supported low volume services, and
- o payments from paying patients have supported charity care patients

This financing pattern has allowed teaching hospitals to meet the needs of their communities and the AAMC has supported it. For example, as recently as 1981, an AAMC Task Force on Graduate Medical Education which comprehensively studied GME recommended that, "graduate medical education should continue to be financed from multiple sources, with the principle source being the general operating revenues of teaching hospitals" (emphasis added).

The current financing system has a number of strengths. To date, patient service revenue has provided a dependable source of funding. This is important for programs with a three to seven year duration. Residents want and deserve a reasonable assurance that the program they enter will still be strong when they are finishing. Secondly, hospitals have been able to develop residency programs that complement and support the hospital's patient care programs. Third, because direct operating costs have been paid on a cost basis, professional judgments on the balance of patient care service and education activities in residency programs have not been influenced by financial incentives. Fourth, because the financial requirements of graduate medical education have been met, a small number of teaching hospitals have trained physicians who go on to serve other communities and hospitals. Finally, the stability of the financing system has enabled accreditation agencies realistically to assume stability of the residency program's quality.

The present financing system, however, does have its weaknesses. First in an increasingly price competitive market for hospital services, hospitals having higher patient charges to support special missions are at a disadvantage. Secondly, the present financing arrangement has worked better for inpatient services than for outpatient services or for non-hospital training sites. As a result, specialties emphasizing inpatient care have been favored over those emphasizing ambulatory care. Training in the surgical specialties has been

advantaged relative to training in general primary care. Third, reimbursed on a cost basis, hospitals have been unable to effectively challenge specialty board efforts to increase the length of residencies and to develop an increasing number of subspecialty programs. Finally, because payroll taxes are used for the Part A trust fund, graduate medical education is supported with a relatively regressive tax.

These strengths and weaknesses of our present system are known. Additional information for use in assessing the present system and alternative arrangements is presently being developed in at least three studies:

- o the HHS Assistant Secretary for Planning and Evaluation's study of the Financing of Graduate Medical Education being performed by Arthur Young and Company;
- o the Commonwealth Fund Task Force on Academic Medical Centers is preparing an analytical paper on "The Future Financing of Teaching Hospitals" using a secondary analysis of existing data; and
- o the Health Care Financing Administration will be preparing four annual reports on the impacts, intended and unintended, of prospective payment on types of hospitals, including teaching hospitals.

In the new environment of hospitals competing on a price basis and third party payers and health care plans favoring hospitals with low charges, teaching hospitals will not be able to compete unless their special contributions to society are recognized and funded. The changes in hospital payments have created an apprehension among members of the AAMC that teaching hospitals will have difficulty in continuing to provide adequate support for clinical education from patient care revenues. Therefore, the AAMC established a Committee on Financing Graduate Medical Education in September, 1984 to evaluate present methods and

explore future alternatives for financing residency training. J. Robert Buchanan, General Director of the Massachusetts General Hospital chairs that Committee and its members are listed in Attachment A. The Committee met with the AAMC Administrative Boards and Executive Council in September, 1984 for a seminar on the financing of graduate medical education. The next three meetings of the committee were held in November, January and February and alternatives for financing graduate medical education were explored.

The Committee concluded substantial disagreements exist within the medical education community about the most appropriate future policy for financing graduate medical education. Therefore, the Committee has prepared a "Statement of Issues" to use in membership discussions and debates. A copy of that "Statement of Issues" is attached to this testimony. The five primary policy issues set forth for debate in that statement can be summarized as follows:

- 1) In a price sensitive environment, will teaching hospitals be able to compete successfully for patient care revenues while continuing to support residency training through patient care, or should separate funding mechanisms be established for GME costs?
- 2) If a separate funding mechanism is established, should the Federal role in such an approach be limited to Medicare and Medicaid patients or should the Federal role be expanded to include full, comprehensive funding of all graduate medical education?
- 3) Since those who pay for residency training may be interested in curtailing the open-endedness of its funding, is it more appropriate to control the number of years of funding per resident or the number of positions to be funded?

- 4) Non-hospital sites are being increasingly used as sites for residency training, particularly for the primary care specialties; how can this change be appropriately recognized in a payment system?
- 5) What responsibility does the American public have for the residency training of FMGs?

The academic medical and hospital community is not of one mind on the alternatives presented by these questions. Therefore, the AAMC cannot, at this time, present a single series of recommendations for the future financing of graduate medical education.

Reagan Administration Proposals

Without addressing the five issues summarized above, the Reagan Administration has proposed two significant changes in Medicare's support of graduate medical education. First, the President's budget proposes a permanent freeze on expenditures for the direct medical education passthrough. As a result, hospitals could never receive more direct GME support from Medicare than they received in the past. In effect, this permanent freeze means Medicare's real support would be diminished by the annual increase in inflation and the hospital's increase in its percentage of Medicare admissions. Second, the President's budget proposes to halve the so-called "indirect medical education" adjustment. This would reduce the adjustment from 11.59% per .1 resident to bed to 5.8% per resident per bed even though HCFA research shows the appropriate amount should be 9% per .1 resident per bed. The Congressional Budget Office estimates that the permanent freeze on direct medical education and halving the resident-to-bed adjustment amount to \$720 million of the President's proposed \$2.3 billion reduction in Medicare's hospital spending. This means teaching

hospitals are being asked to absorb 31% of Medicare's reduction in hospital payments.

The AAMC is strongly opposed to the proposed permanent freeze on the direct medical education passthrough and to the halving of the resident-to-bed adjustment. The President's budget presents these proposals as simply expenditure reductions. While the proposals would reduce Medicare spending, the Administration's proposals would also have a dramatic, adverse impact on GME financing and on the financial stability of teaching hospitals. To maintain high quality training programs, teaching hospitals may try to shift GME costs to other payers. This will be difficult in competitive environments where payers oppose cost shifting and in regulatory environments where the rate-setting agencies try to maintain a balance between the prices of various payers. Therefore, shifting Medicare's share of GME costs to other payers will be impossible for many teaching hospitals. The long run options are equally unattractive. The teaching hospital can (1) try to find another source of funds, (2) alter its other patient care and research missions, (3) reduce the size of its training program, or (4) weaken its financial stability by reducing its ability to accumulate the capital necessary for new programs and institutional development. Most teaching hospitals will probably try more than one of these strategies, with the precise mix depending upon the hospital's local environment.

Since its inception, Medicare has supported its fair share of these GME costs. Reducing Medicare support will weaken manpower development programs. It will also set a precedent which other payers may cite as the basis for reducing their support. Rather than having deficit reduction politics determine future health manpower policy, the AAMC strongly recommends that public policy on financing graduate medical education be fully debated and resolved prior to altering Medicare's present payment policies.

A Final Comment

It should be recognized that the American system for graduate medical education is grounded in the teaching hospital. Graduate medical education cannot function effectively unless teaching hospitals are compensated for the added costs associated with their responsibilities. For the last two decades, the financing of teaching hospitals has been adequate and stable and permitted the development of high quality GME programs which have trained thousands of competent physicians annually. As medical schools responded to a national policy of increasing physician graduates, hospitals responded by expanding residency training. Now, however, the financial stability of teaching hospitals is at risk. New payment systems being introduced assume that patients with the same illness require the same intensity of care and utilization of resources. This approach does not take into account the generally greater complexity of illness of patients treated in teaching hospitals or the costs of graduate medical education which prepares the next generation of physicians. In a "prudent buyer," price competitive market, tertiary care/teaching hospitals will fail financially because paying an average price per case does not meet the financial requirements of the teaching hospital's special services. Even a subsidy for graduate medical education will be insufficient if it does not include additional expenses for tertiary care services, stand-by services, new technology, and charity care in addition to graduate medical education.

Teaching hospitals are a diverse group of highly complex institutions performing medical education and research services for the nation and providing both basic and tertiary patient care. The current emphasis on re-examining national policies in light of more limited public resources places teaching hospitals and their vital activities at significant risk if their special nature and role are not appreciated. As policies and expectations change, teaching

hospitals will continue to adapt and evolve. If developing national policies on health care delivery and payment recognize the distinctive characteristics and diversity of teaching hospitals, their fundamental missions can be preserved. If the characteristics of teaching hospitals are not recognized and valued, simplistic public policies may damage the ability of these institutions to fulfill their multiple responsibilities. The Association is pleased that this Subcommittee and its chairman appear willing to study all of these issues before embracing proposed solutions.



**association of american
medical colleges**

**AAMC COMMITTEE ON
FINANCING GRADUATE MEDICAL EDUCATION**

Statement of Issues

March, 1985

one dupont circle, n.w./washington, d.c. 20036

In the last five years, the AAMC has completed comprehensive reviews of both graduate and undergraduate medical education.* Among the common themes of these reports is the conclusion that a contemporary medical education requires completion of both medical school and residency training in order to be prepared for independent medical practice. Medical schools provide the general professional education which is the foundation of all medical practice. Residency training or graduate medical education provides the formal clinical education that develops the skills and experience necessary for independent practice. Residency programs are accredited by the Residency Review Committees under the supervision of the Accreditation Council for Graduate Medical Education.

Graduate medical education is not focused on the university campus. It takes place primarily in teaching hospitals. Residents, working under supervision, learn clinical medicine by hands-on participation in the care of hospital patients. Patients are being treated and residents are being trained through the same activities. In effect, both products -- patient care and education -- are being simultaneously, or jointly, produced in the teaching hospital.

The joint product nature of patient services and clinical education does not imply that education is being produced without additional costs -- education is not simply a by-product. Adding the educational role involves additional costs for supervising faculty, clerical support, physical facilities, lowered productivity, and increased ancillary service use. These costs are real. If graduate medical education is to continue, these costs cannot be avoided. Therefore, the growing debate about financing graduate medical education should

*Graduate Medical Education: Proposals for the Eighties (1981) and Physicians for the Twenty-First Century (1984).

not be one about paying or not paying these costs. Rather, the debate should be about the most appropriate method of paying for the costs of residency training.

For the past several decades, the teaching hospital's added costs for residency training have been financed primarily by patient service revenues, most particularly by payments of hospital charges and reimbursement. For example, data from the AAMC's 1984 survey of stipends paid to housestaff show 81% of the stipends and benefits are paid from hospital patient revenue when Federal hospitals are excluded. The next largest source, state appropriations, supports only 5% of residents' stipends. For advanced residents, called clinical fellows, the role of hospital revenues is somewhat smaller, but still accounts for over 61% of funding. While residents' stipends are only one major cost of these programs, the AAMC believes patient service revenue has been and continues to be the primary source for supporting the total costs of graduate medical education.

The AAMC has had a long-standing policy on financing graduate medical education which was reaffirmed in 1980 when the AAMC published the report of its Task Force on Graduate Medical Education. This three-year task force recommended that:

Graduate medical education should continue to be financed from multiple sources, with the principal source being the general operating revenues of the teaching hospital (p. 94, emphasis added).

The recommendation was consistent with private payer practices and with Congressional intent for the Medicare program. Many Blue Cross agreements throughout the country explicitly provide for payment of these costs. Congress clearly established payments for residents in training as a legitimate Part A Medicare expense in the original Medicare statute.

The AAMC continues to believe patient charges and reimbursements are an appropriate method of financing graduate medical education. In fact, if all, or most, of the nation's hospitals participated in graduate medical education, patient service financing of residency training could survive in the face of the increasingly competitive hospital marketplace. However, only 2 percent (125) of the nation's 5,900 community general hospitals provide 50 percent of the nation's residency training. Another 1,100 hospitals provide the remaining half of residency training. These 1,225 hospitals bear the cost of training the nation's entire supply of residents. The remaining 4,600 community hospitals -- as well as health maintenance organizations, competitive medical plans, and preferred provider organizations -- obtain the benefits of fully trained physicians without sharing in the cost of the training itself. This gives the non-teaching hospital an advantage in setting its charges and negotiating contracts. In the new environment of hospitals competing on a price basis and third party payers and health care plans favoring hospitals with low charges, teaching hospitals will not be able to compete unless their special contributions to society are recognized and funded.

The changes in hospital payments have created an apprehension among members of the AAMC that teaching hospitals will have difficulty in continuing to provide adequate support for clinical education from patient care revenues. Therefore, the AAMC established a Committee on Financing Graduate Medical Education in September, 1984 to evaluate present methods and explore future alternatives for financing residency training. The Committee is chaired by J. Robert Buchanan, M.D., general director of the Massachusetts General Hospital, and the members are listed in Attachment A. The Committee met with the AAMC Administrative Boards and Executive Council in September, 1984 for a seminar on the financing of graduate medical education. The next three meetings of the Committee were held in November, January and February and alternatives for financing graduate medical

education were explored. This paper has been prepared to summarize the discussions of the Committee and to explain the competing views on the issues of financing graduate medical education reviewed by the Committee.

The Committee's discussions have focused on five topics:

- o the need for special funding for graduate medical education in the patient care payment environment that is evolving;
- o the advisability of creating a societal funding mechanism for graduate medical education rather than having each payer establish its own policies;
- o the number of training years to be financed with any separate funding and the resulting manpower controls that accompany various alternatives;
- o the increasing use of non-hospital sites, especially ambulatory care settings, for residency training; and
- o the responsibility for training physicians educated in foreign medical schools.

The remainder of this report explores each of these topics in some detail in order to provide AAMC members, physicians and hospitals, third party payers, and public policy analysts with an understanding of the conflicting viewpoints within the medical education community.

The Need for Separate Funding

Patient care financing of graduate medical education has well served teaching hospitals, physicians-in-training, and society for several decades. Hospitals have been able to expand positions available to meet the increasing number of medical school graduates, specialties have upgraded their basic clinical training requirements, new subspecialties in medicine and surgery have developed, and new technologies have been widely disseminated.

Some Committee members and some AAMC members believe that teaching hospitals may be able to compete in the new environment without separate funding for the higher costs that result from graduate medical education. Until evidence to the contrary is clear, they believe that it would be unwise for the AAMC to advocate alternate financing arrangements which may jeopardize some of the benefits of the current system. These benefits include the freedom of medical students to elect to train in the specialty of their choice and the ability of teaching hospitals to offer a variety of residency programs.

The competing view, held by the majority of the Committee and many AAMC members, is that patient revenues in the future price-competitive market may be insufficient to support financing of graduate medical education and that alternatives must be found or at least explored. This group believes payers will withdraw their explicit support and/or cut back on their implicit support for graduate medical education. As a result, teaching hospitals will be forced either to limit other hospital programs and services to support the educational mission or to reduce the numbers of residents and faculty they support. Other missions also may increasingly draw on the resources of the teaching hospitals. For example, many teaching hospitals are being asked to provide increasing amounts of care to the indigent without concomitant increases in state or local

support. Thus, institutional resources are being stretched substantially and may be unable to support educational programs at current levels.

In substantial part, this dichotomy of viewpoints reflects different member experiences and points of reference. Those who advocate continuing to finance graduate medical education with patient service revenues present their viewpoint with reference to a payment system based on negotiated prices. They believe the teaching hospital has a marketable resource in its educational activities. They see education providing a quality-enhancing benefit not available from non-teaching hospitals. Moreover, in a negotiated market, a hospital is free to reject a price which does not enable it to meet its patient care and educational costs.

Those who advocate establishing separate financing for graduate medical education present their view with reference to a payment system based either on administered prices set by an external entity or on a payment system dominated simply by lowest price. For example, Medicare's basic prospective payment formulas are designed to pay a fixed price for a given patient irrespective of whether the hospital does or does not offer residency training. Unless separate funding is added, such as Medicare's current medical education passthrough, the teaching hospital must provide two products (i.e., patient care and education) for the same price the non-teaching hospital must provide only patient care. For non-Medicare payers, if price is the only selection criteria, there will not be additional funding for graduate medical education.

Given these differing reference points and perspectives, the AAMC faces two fundamental but conflicting assumptions:

public and private payers will recognize the unique contributions and benefits of teaching hospitals and be willing to pay teaching hospitals higher payments. As a result, the AAMC need not explore alternative arrangements for financing graduate medical education;

or

public and private payers of hospital services are becoming increasingly resistant to including adequate funding for the support of graduate medical education in their general patient care payments. As a result, the AAMC must explore options to provide support for this essential mission of teaching hospitals.

Resolution of this fundamental difference in working assumptions must precede discussions about the methodologies and structures for financing graduate medical education.

The Committee premised its development of alternative financing arrangements on the latter assumption cited above. This does not imply that it is inappropriate to finance GME with the general operating revenues of teaching hospitals. It does recognize, however, that in the future new payment systems for patient services may not provide teaching hospitals with sufficient funds to finance both their patient care and educational missions. Therefore, the Committee has explored alternatives and identified conflicting issues that must be resolved.

Scope of Proposals

Health care financing arrangements, both public and private, are undergoing substantial changes:

- o payers are increasingly interested in paying only for the immediate services used by their beneficiaries,
- o predetermined payments are replacing retrospective cost reimbursement, and
- o low price is replacing access as a criteria for selecting hospitals.

In this environment, each payer has an economic advantage in behaving as a marginal price purchaser paying only the incremental costs arising from services provided to its patients. This behavioral incentive, however, is in conflict with the broader societal interest in maintaining and supporting commonweal services benefiting all collectively but no payer individually.

Adequate financing for graduate medical education requires each payer to subordinate some of its economic self-interest to the broader social interest of adequately training new physicians. This subordination of self interest can be achieved in two ways: (1) society can impose a tax to support the costs of residency training or (2) payers can individually be persuaded for social, ethical, or public image reasons to share in financing residency training.

The Committee recognizes advantages and disadvantages to each approach. The taxation approach is the most likely to provide comprehensive financing and to avoid conflicting health manpower policies across payers. However, requiring a Federal tax, administered by Federal officials, seems to be contradictory to the present political climate. Moreover, it would make residency training dependent on a single source of funds and subject it to annual debates in the Federal budget. Such fiscal control could lead to massive intervention in medical education. Similar reservations exist for state-administered taxes. In addition, a state tax approach could lead to conflicting manpower policies across the nation.

The individual payer approach does not require major Federal legislation or a new bureaucracy and it permits manpower training decisions to remain at the institutional level. It is not clear, however, whether payers will subordinate their economic self interest. Some may; others may not. As a result, the revenue base for residency training may be incomplete and constantly changing.

The preferred course is unclear. Should the AAMC seek a comprehensive, national tax or should the AAMC concentrate on national payers (e.g., Medicare) while individual members work with their state and with individual payers? Each choice has major risks.

The Training Period To Be Funded

If separate funding is provided to support graduate medical education, the amount of that funding could be set by determining the number of residents to be financed and the number of training years to be supported. Three options on the length of training which would be supported by separate funding are available: (1) fund residents for a fixed number of years (e.g., 3, 4, or 5) regardless of the specialty in which the resident is training; (2) fund residents only for the period of time necessary to obtain initial board eligibility; or (3) fund residents in all accredited programs for initial and subspecialty training.

Option one provides separate funding for a fixed number of years per resident. Residents in programs which can be completed in the fixed number of years are supported throughout their training. Residents in the longer programs would receive funding for the fixed number of years but they, the hospital and the staff physicians would have to support the remaining years with patient service revenues, grants, appropriations, contracts, or philanthropy. For example, if the separate funding were provided for the first three years of residency training, residents in three year programs would be supported for all training years. Residents in programs lasting four or more years would receive separate funding only for the first three years of their program. Thus, under the three year example, residents in family practice, pediatrics, and internal medicine would receive funding throughout their basic training. Residents in all other specialties and subspecialties would receive funding only for the first three years of their program. Advocates of fixed year funding emphasize two

advantages to the approach. First, it minimizes external regulation. It does not require an external entity to allocate residency positions by specialty or across hospitals because payment is made based solely on the number of residents at or below the fixed years of training. Secondly, the advocates generally believe it will increase the proportion of residents training in the primary care specialties and decrease the proportion of residents undertaking subspecialty training. Detractors are concerned that the fixed year funding creates instability and uncertainty for residency programs lasting beyond the fixed year threshold. They note that strong training programs are built across time and need stability of financing and personnel. Detractors are also concerned that funding less than the years required for certification may lead to: inappropriate efforts to shorten training time, residents who drop out of training programs before completing them, or fee-for-service billing for residents who have not completed their training programs.

A second alternative varies the number of years of separate funding with the number of years of specialty training required for initial board certification. Residents in internal medicine would be supported for the three years of internal medicine with no separate funding provided for subspecialty training. Residents in surgery would be supported for the five years required for general surgery with no additional separate funding provided for the extra years required for thoracic, plastic, or colon and rectal surgery. The principal advantage of this alternative is its explicit recognition of the variation in the time required for initial board certification in different specialties. Some Committee members are concerned that separate funding which varies with the training required for initial board eligibility may lead to the development of a manpower planning entity which designates the number of approved positions in each specialty. The majority of the Committee believes, however, that a manpower planning entity is not necessary if separate funding is limited to the initial training program.

The majority also believes their position would be strengthened if the number of years of support for each specialty is limited to the present requirement. The major disadvantage of this alternative is its limitation to initial board eligibility. In many specialties -- including internal medicine, pediatrics, and surgery -- some residents undertake subspecialty training after they have completed, or could have completed, the initial residency. This alternative would not provide separate funding for residents in subspecialty training. Other sources of financing would be needed to support subspecialty programs.

The third alternative provides separate funding for all residents training in approved training programs. This approach provides separate funding for full specialty and subspecialty training in all disciplines. Advocates of this approach emphasize that it provides full funding for the period of time that the physician-in-training is subject to the direction and supervision of faculty. It does not provide an economic disincentive to developing or pursuing the longer training programs. Detractors note the open-endedness of this approach. They believe the funding entity is likely to limit its financial exposure under this option by developing explicit manpower training policies. The detractors are concerned that some entity may determine how many positions in each type of training will be offered and which hospitals will be approved for funding.

The three funding options are dramatically different. They vary in terms of ease of administration, financial comprehensiveness, and likely manpower regulation. Each approach has supporters. Selection of any one approach will bring fundamental change to residency training.

Non-Hospital Training Sites

Increasingly, acute care hospitals are being used only for the most intensive portion of a patient's illness or procedure. This has changed both the kinds of cases admitted to inpatient units and shortened the length of time the patient is in the hospital. As a result, several specialties are now trying to incorporate non-hospital experiences in their residency programs. This creates problems because hospital patient care revenue has been the predominate source of support for residency training. While hospital charges and costs presently include expenses for graduate medical education programs, ambulatory care providers do not have such costs in their present charges. Increasing charges in ambulatory or long-term care settings to support residency training would disadvantage some providers as price competition in all areas of medical care increases. Innovative financing approaches must be developed and evaluated for both long-term care and ambulatory settings.

Residency Positions To Be Supported

The United States has 127 medical schools accredited by the Liaison Committee on Medical Education (LCME) and 15 accredited osteopathic schools from which there are a total of approximately 16,200 graduates. The AAMC Committee believes that the United States has an obligation to provide the resources necessary to train these graduates. The Committee believes society has no similar obligation to provide and financially underwrite graduate medical education for graduates of non-accredited medical schools or schools outside the U.S. At the present time 18% of residency training positions are occupied by physicians graduating from foreign medical schools. While some U.S. hospitals may wish to continue training foreign graduates, the Committee believes such training need not be supported by funding arrangements designed to support graduate medical education. Because almost twenty percent of current residents

are foreign medical graduates, adoption by payers of the Committee's position would substantially reduce the funding needed for graduate medical education.

Conclusion

This statement of issues is focused on five major topics surrounding the future financing of graduate medical education. The Committee recognizes that numerous secondary issues have not been addressed. For example, approaches which increase the uncertainty of residency support may discourage economically-disadvantaged individuals from choosing a medical career. Eliminating funding for foreign medical graduates may pose special transition problems for patient services in some hospitals. The Committee is aware of these and other secondary concerns but chose to omit them in order to address the primary topics in a more tightly focused way.

During the last two decades, hospitals have operated for the most part in a cost reimbursement era with substantial autonomy. They have competed with each other on the basis of quality and scope of services; there was minimal competition on the basis of price. The Committee recognizes that the environment of the mid-80's and beyond is different and that hospitals must improve the efficiency of all their services. Price per unit of service is becoming the basis of competition. Even efficient teaching hospitals are disadvantaged in the price competitive market for a variety of reasons including:

- o the provision of a disproportionately large share of care to the indigent;
- o the treatment of the most severely ill patients;

- o the provision of regional stand-by services, such as burn centers, pediatric and adult open-heart surgery centers, and transplant centers;
- o the presence of clinical research efforts to advance diagnostic and treatment capabilities; and
- o the provision of graduate medical education to maintain the supply of physicians for this country.

All of these functions are important to the missions of teaching hospitals, and all make teaching hospitals more expensive to operate than non-teaching hospitals. The Committee's task is to examine only changes in the financing of graduate medical education, but it clearly recognizes that even if separate funding for graduate medical education is adopted, teaching hospitals will continue to require special consideration in any hospital financing scheme for the other functions that distinguish them from non-teaching hospitals. While financial support for graduate medical education will not eliminate the teaching hospital's problems, support for GME will contribute to a more equitable market in which teaching hospitals are less disadvantaged.

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**THE MEDICARE ADJUSTMENT FOR THE
INDIRECT COSTS OF MEDICAL
EDUCATION: HISTORICAL DEVELOPMENT
AND CURRENT STATUS**

**Judith R. Lave, Ph.D.
University of Pittsburgh
January, 1985**

This report was prepared under a contract with the Association of American Medical Colleges. I would like to thank James Bentley, Richard Knapp, Julian Pettengill and Lester Lave for comments and criticisms on earlier drafts. I alone am responsible for the interpretation and conclusions.

PREFACE

An integral part of the recently enacted Medicare Prospective Payment System is the "indirect medical education adjustment," yet there is a great deal of misunderstanding concerning the purpose of this adjustment. Its title has led many to believe that this adjustment to the DRG prices is to compensate for education and related program costs. However, its congressional sponsors and the AAMC have recognized from the beginning that these payments are in fact necessary to recognize the costs of tertiary care and the unique services which are most commonly provided in teaching hospitals, and the limitations of the Diagnosis Related Groups as a unit of payment.

In order to clarify the intent of this "indirect medical education adjustment," the AAMC contracted with Judith Lave, Ph.D., Professor of Health Economics at the University of Pittsburgh and former director of the Office of Research within the Health Care Financing Administration, to write her perceptions of the history and purposes of the indirect medical education adjustment.

I believe Dr. Lave has done an excellent job and provided a document which gives a thorough and thoughtful account of the development and intentions of this adjustment. I believe the document is worth your attention.

John A. D. Cooper, M.D.

EXECUTIVE SUMMARY

The concept of the indirect costs of medical education was introduced into the hospital payment lexicon in 1980 by the Health Care Financing Administration (HCFA). HCFA stated that in calculating the then "Section 223" cost limits, per diem allowable costs could be adjusted for a number of factors including the number of residents per bed. The "medical education" adjustment was included to account for the increase in per diem costs found to be associated with the number of residents per bed.

Since then, Medicare's reimbursement policy has been fundamentally changed. Retrospective cost based reimbursement is being supplanted by a prospective payment system. Under the fully implemented Medicare Prospective Payment System (PPS), Medicare's share of capital and direct graduate medical education costs still will be paid on the basis of reimbursable costs while prospectively set DRG payments will cover Medicare's share of hospital operating costs. In addition to the standard DRG payments and the cost reimbursed passthroughs, teaching hospitals will receive incremental payments tied to the number of residents per bed. These payments, which have become known as payments to cover the indirect costs of medical education, will account for approximately 5.5 percent of total Medicare payments under the fully implemented PPS system.

In the following overview, the concept of indirect medical education adjustment is discussed first. Next the approach used by HCFA to estimate this adjustment is outlined. Third the factors leading up to

the doubling of the HCFA estimated adjustment and the implications of the doubling are discussed.

The size of payments made under the rubric "payments to cover the cost of medical education" makes the adjustment an easy target for budget cuts. However, if these payments are to be cut it is necessary that accompanying changes be made in PPS. Therefore, the paper concludes by describing changes which would enhance the equity and efficiency of PPS not only for teaching hospitals, but all hospitals and patients, including:

- recategorization of some of the more heterogeneous DRGs,
- improvements in the setting of the DRG relative prices,
- determination of improved wage indices,
- reassessment of the definition of the market for which factor price differences will be taken into consideration, and
- reconsideration of the number of locational factors that will be used in adjusting the standardized DRG rates for different hospitals.

Some of the changes, such as the DRG classification system, HCFA already has under examination. Others, such as a reconsideration of the market areas, have been virtually ignored. All, however, are of vital importance if the PPS is to provide the equity across hospitals that is required for a long term payment reform.

Introduction

On April 1, 1980, a proposed rule (NPRM) in the Federal Register introduced a new concept into the hospital payment lexicon: the adjustment for the indirect costs of medical education. In setting the proposed schedule of limits for hospital inpatient general routine operating costs for cost reporting periods beginning on or after July 1, 1980, the Health Care Financing Administration (HCFA) stated that Medicare allowable costs could be adjusted for differences among hospitals in location (urban/rural), area wage rates, bed size, and the number of interns and residents per bed. The adjustment for the number of interns and residents per bed was included to account for the increased per diem costs "due to approved medical education programs".¹

Since then, Medicare hospital reimbursement policy has been fundamentally changed: retrospective, cost based reimbursement is being replaced by a prospective payment system. The new system includes explicit additional payments to teaching hospitals. These payments, which are also directly related to the number of interns and residents per bed, are described in the implementing regulations as compensation for the "indirect costs" of education. These payments will account for approximately 5.5 percent of total Medicare payments for hospitals under the fully implemented prospective payment system.²

Now under the pressure of large and persistent federal budget deficits, the social policy of subsidizing graduate medical education through increased payments for patient care is increasingly open to question. In addition, given the "budget neutrality" of the new system more payments to hospitals with large graduate medical education programs means lower payments for those hospitals with none. Some have argued that the additional payments to teaching hospitals are unfair as they reward uneconomic behavior in those hospitals. The teaching hospitals, however, stress that their higher costs are related to legitimate differences in other factors associated with teaching programs, such as the severity of illness, that make their patients more expensive to treat. Thus, they maintain these extra payments should not be described as subsidies for teaching but as legitimate payments in recognition of other factors not adequately accounted for in the new system.

Given the magnitude of the payments resulting from the resident to bed adjustment, it is important to understand its origin and evolution. This paper begins with a brief discussion of the background events leading up to the introduction of the resident to bed adjustment in 1980. Next, it describes how the adjustment was incorporated into the new Medicare hospital prospective payment system. It then goes on to examine the factors that contribute to the observed relationship between the number of residents per bed and Medicare operating costs per case. This section

sets the basis for a consideration of the factors that must be explicitly considered as the prospective payment system evolves.

Background to the April 1, 1980 NPRM

Section 223 of the Social Security Amendments of 1972 authorized the Secretary of Health, Education and Welfare to set prospective limits on the amount of costs authorized for reimbursement to institutional providers under Part A of Medicare. These limits were to be based on the estimated costs necessary to provide needed services efficiently. Such estimates, however, are extraordinarily difficult to make. Given the limitations of data and methods at that time, early efforts to implement this provision focused on setting limits on hospital routine per diem costs. Routine per diem costs sufficiently above the costs of comparable hospitals were considered unreasonable and therefore not reimbursable.

Between 1974, when the regulations implementing the legislation were first published, and 1980 the methods used to establish the limits were changed in a number of ways. These changes stemmed from three interacting conditions: (1) improvements in the Federal government's ability to classify hospitals and thus to compare hospital costs, (2) a steady lowering of limits due to the improvement in classification systems and increasing pressure for Federal budget savings, and (3) revision of the methods to compare costs to respond to the needs of groups of institutions which were disproportionately affected by the lowering of the limits.

For the purpose of this paper, one such change should be noted. In 1979 it was decided that in calculating its routine per diem costs, a hospital could exclude all direct teaching costs. The direct costs for teaching were excluded because it did not seem fair to compare the routine per diem costs of nonteaching hospitals to those of teaching hospitals if the direct costs of teaching were included. The costs of teaching hospitals would surely be higher. This exclusion set a precedent for separating out direct teaching costs, a separation that carried over into the design of the Medicare Prospective Payment System.

By 1979, the cost limits were set at the 80th percentile of the costs of comparable hospitals; and the hospital size, location (urban/rural) and area wage rates were taken into consideration in determining comparability among hospitals. The Administration intended to lower the Section 223 limits further. However, any significant reduction in the limits would have hurt many hospitals; and, without any change in the grouping methodology, it would have had a particularly severe impact on teaching hospitals, especially those with very large graduate medical education programs. Thus political pressure was put on the Department of Health and Human Services (the successor of the Department of Health, Education and

Welfare) to take the special circumstances of the teaching hospitals into account.

Two options were considered to adjust for the higher costs of teaching hospitals. The first option was to create special groups of teaching hospitals. Grouping variables considered included: nature of affiliation with a medical school, the number of approved residency programs and the number of interns and residents (hereafter residents) per bed. However, data analysis did not reveal any obvious groups; for example, there were no clear cut breaks in the distribution of the number of residents per bed. Thus any effort to form groups would have created a significant boundary problem. The second option was to use a continuous adjustment procedure. Statistical analysis suggested that, after controlling for bed size, location and area wages, routine costs per day in teaching hospitals increased on average 4.7 percent with every .1 resident per bed. This empirical relationship could be used to adjust a hospital's limit.

The Office of Research in HCFA recommended application of this teaching adjustment factor (to the limit that otherwise would have been set on the basis of bed size, wage level and location) in determining the routine cost limits for teaching hospitals. At the same time it acknowledged that, despite this observed relationship, the specific cost elements increased by the level of teaching activity were not identified.³ The recommendation to use a resident to bed adjustment was accepted, but not without discussion. There was some concern expressed within HCFA that the higher costs of teaching hospitals were due to lower levels of productivity and that pressure should be placed on these institutions to become more efficient. In addition, there was some concern that this adjustment might lead to an expansion in the number of residency programs.

The April 1980 NPRM and the June 1980 final rule made a number of changes in prior regulations: they lowered the limit from the 80th percentile of the cost distribution of comparable hospitals to 112 percent of the mean and they provided for an adjustment in the limit depending on the number of residents per bed. An explanation of the adjustment for the allowed higher costs for teaching hospitals was given in the April NPRM.⁴

We believe these increases in per diem costs occur because the provision of graduate medical education causes increases in certain types of costs that are only indirectly related to education programs. For example, a hospital with an approved medical education program may be required, for training purposes, to maintain more detailed and complete medical records than a nonteaching hospital. However, medical records are not considered educational expenses and, therefore, are not excluded from the costs subject to the limitation under the current schedule.

Thus, this adjustment was clearly labelled an adjustment for the *indirect* costs associated with medical education programs.

The Adjustment for Medical Education Under Prospective Payment

Between 1980, when the resident to bed adjustment to the limits was adopted, and 1983 when the prospective payment legislation (PL-98-21) was passed, the approach taken to adjust for the higher costs of teaching hospitals remained unchanged. While the 223 routine cost limits were in effect, the 4.7 percent adjustment for the indirect costs of medical education continued. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) made fundamental changes in the way that hospitals were reimbursed under Medicare—it extended the 223 limits to cover total operating costs per discharge and it set a limit on the allowable rate of increase in operating costs per case. Nevertheless, the method used to set the total operating cost limits for teaching hospitals paralleled that for the routine cost limits—the limit was adjusted upwards with the number of residents per bed and the magnitude of the percentage adjustment was determined by a statistical analysis similar to one used to set the adjustment to the routine limits.

The TEFRA legislation directed the Secretary of Health and Human Services to report back to the Congress by December 1982 on a method to set prospective payments for hospitals under Medicare. In designing the new system, the Secretary made an early policy decision that Medicare would pay a single price for a given product. The issues of the teaching hospitals and methods to pay for graduate medical education were reopened and alternatives to the current adjustment procedures were explored.⁵ The decisions reached were laid out in the Report to the Congress.

The first major decision had to do with paying for the direct costs of teaching.⁶

The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.

The second major decision had to do with the indirect costs of teaching.⁷

The indirect costs of graduate medical education are the higher patient care costs incurred by hospitals with medical education programs. Although it is not known precisely what part of these higher costs are due to teaching (more

tests, more procedures, etc.), and what part is due to other factors (the particular types of patients which a teaching hospital may attract), the Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals.

It is also true that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education results in very intensive treatment regimens. Again, the relative importance of the various reasons for the higher costs observed in teaching hospitals is difficult to identify precisely. However, there is no question that hospitals with teaching programs have higher patient care costs than hospitals without.

The Department believes that recognition of these indirect costs should be accomplished through a lump-sum payment, separate and distinct from the base rate. This adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total cost limits for the indirect costs of graduate medical education. The hospital's cash flow will be preserved by some sort of periodic payment.

The Secretary's proposal established a fee schedule for hospital services. The Diagnosis Related Groups, the DRGs, were the recommended unit of payment and the prices set for the DRGs were based on an estimate of the average cost of each DRG. The DRG payments were to cover the operating costs of providing inpatient hospital services to Medicare beneficiaries. DRG prices would vary with hospital wages in the area, hospital location (urban/rural) and the extent of teaching. (Although the actual payment for the indirect teaching adjustment is to be made as a lump sum, it is useful for discussion purposes to think of it as an adjustment to the rate). The DRG payments were to cover the operating costs of providing inpatient hospital services to Medicare beneficiaries.

The Secretary originally proposed that after adjusting for hospital wages and location, the DRG payment should increase by 5.79 percent for each .1 increase in the number of residents per bed. As before, this adjustment factor had been estimated statistically. However, in this case, there was a difference between the factors that were controlled for in estimating the adjustment factor and those factors the Secretary recommended be taken into consideration in setting the rate. This point, which is very important, is further developed below.

In determining the statistical relationship between hospital operating costs per discharge and residents per bed, analysts controlled for hospital case mix, area wages, bed size, and the size of the geographic area in which the hospital was located.⁸ The statistical results indicated that controlling for the other

factors included in the analysis, the Medicare operating cost per case increased approximately 5.79 percent with every .1 increase in the number of residents per bed. The analysis also indicated that Medicare costs increased with hospital bed size and that the costs of hospitals located in Metropolitan Statistical Areas (MSAs) with over a million population were much higher than those in rural or in smaller urban areas. Thus, the Secretary's decision to vary the price paid for each DRG only with the hospital's case mix, residents per bed, area wage level and location (based on a simple urban/rural split) meant that large hospitals located in large urban areas would be relatively adversely affected by the payment system. These characteristics, however, are exactly the characteristics of hospitals with large graduate medical education programs. Of the 329 non-federal hospitals that are Council of Teaching Hospitals (COTH) member hospitals, 74 percent have more than 399 beds (compared to 7 percent of the 5,655 nonmember hospitals), and 61 percent are in urban areas with populations of 1,000,000 or more (compared to 23 percent of nonmember hospitals).

The extent to which certain types of hospitals would be adversely affected by the proposed system, was vividly indicated in an impact analysis prepared by the Congressional Budget Office (CBO). CBO presented preliminary information on the characteristics of hospitals that would gain or lose under the Secretary's proposed plan. These estimates are presented in Table I. Here it is shown that 70 percent of the hospitals with over 300 beds, 57 percent of urban hospitals and 71 percent of teaching hospitals would be adversely affected.

The negative effect of the proposed system on the nation's teaching hospitals was larger than was desirable or politically tolerable. In response to this problem, the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services suggested that the adjustment for medical education be doubled from 5.79 (the original proposal) to 11.59 percent for each .1 increase in the resident to bed ratio. This was an expedient proposal which, as will be argued below, temporarily "solved" the problem of the teaching hospitals without addressing a major source of the problem; that is, that the Secretary's proposal did not adjust adequately for the differences in the market areas in which those hospitals were located.

Before passing the prospective payment legislation, the Congress accepted the suggestion of the Assistant Secretary and made several other changes to the Secretary's proposed plan. The most important of these was the introduction of a phase-in period during which the DRG prices paid to a given hospital would move from being based almost entirely on its own historical operating costs to being based on the average costs in urban or rural areas; that is, to move from a hospital specific rate to a national urban or rural rate. Under the fully implemented system, these

Table 1
Estimated Average Penalties and Bonuses Under the Administration's
Proposed DRG-Based Payment System
By Type of Hospital^a

	All Hospitals		Hospitals That Would Gain		Hospitals That Would Lose	
	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements ^b	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements ^c	Percent Distribution of Hospitals	Aggregate Effect as Percent of Reimbursements ^d
All Hospitals	100	0 ^e	61	+ 23	39	- 12
Bed Size						
Less than 100	49	+ 23	80	+ 35	20	- 10
100-299	34	+ 2	50	+ 21	50	- 11
300 +	17	- 6	30	+ 17	70	- 13
SMSA						
SMSA	52	- 4	43	+ 20	57	- 13
Non-SMSA	48	+ 19	81	+ 29	19	- 6
Region						
Northeast	15	- 4	45	+ 19	55	- 12
North Central	28	- 4	60	+ 21	40	- 13
South	37	+ 8	72	+ 26	28	- 9
West	20	- 2	57	+ 23	43	- 13
Teaching Status						
Teaching	18	- 7	29	+ 18	71	- 13
Nonteaching	82	+ 7	69	+ 24	32	- 10
Ownership						
Nonprofit	57	- 2	55	+ 20	45	- 12
Government	31	+ 9	78	+ 29	22	- 12
Proprietary	12	- 1	48	+ 22	52	- 13

SOURCE: Preliminary CBO estimate based on Medicare Cost Reports for 1980.

- a. Assumes an average payment level needed to keep outlays at the same level as under TEFRA in fiscal year 1984. Average gains and losses are incremental to those under TEFRA, which are assumed to be the average for each group. Effects of phase-in and adjustments for exceptionally costly cases are excluded, but an adjustment for teaching hospitals is included.
- b. Average calculated for all hospitals.
- c. Average calculated for hospitals that would gain.
- d. Average calculated for hospitals that would lose.
- e. Because aggregate reimbursements were assumed to be the same as under TEFRA, increases in payments to some hospitals would be exactly offset by decreased payments in others.

Source: Nancy M. Gordon, statement before the Subcommittee on Health Committee on Ways and Means, U.S. House of Representatives
 February 14, 1983

rates would vary only with those factors recommended by the Secretary, the resident to bed ratio and area wage rates. However, both the House and the Senate in their committee reports commented on the increased resident to bed adjustment. The Senate stated:⁹

This adjustment is provided in the light of doubts . . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.

The regulations implementing this legislation made the following statement with respect to the resident to bed adjustment:¹⁰

Section 1886(d)(5)(B) of the Act provides for additional payments to be made to hospitals under the prospective payment system for the indirect costs of medical education.

This cryptic comment could imply that the Department views the additional payment as primarily an additional outlay to cover the indirect costs of medical education and not to compensate for the weaknesses in the DRG system.

At this point, however, it is useful to leave the legislative and regulatory environment and to consider the adjustment, and what it represents, in more detail.

The Indirect Teaching Factor: What Does It Really Measure?

Nationally, the observed operating costs of hospitals with large graduate medical education programs are considerably higher than those without such programs. The important question is why are their costs higher? Are the costs of teaching hospitals higher because these hospitals treat sicker and more complicated patients who are more costly to treat? Are the costs of these hospitals higher because they tend to be located in the central cities of large metropolitan areas where it is more expensive to provide hospital services, or are their operating costs higher because it is more costly to treat patients in these hospitals? In this section these issues are addressed.

A preliminary answer to these questions is given by reexamining the results of the statistical analysis done by HCFA.¹¹ HCFA analysts studied the factors associated with Medicare costs per case. They ascertained that costs rose proportionately with the Medicare Case Mix Index (a measure of the costliness of a hospital's case mix as measured by DRGs)

and the average wages paid to hospital employees in the SMSA in which the hospital was located. They also determined (other things being equal) that relative to hospitals located in rural areas, hospital costs in urban areas with less than 250,000 people were only slightly more costly, that hospitals located in areas with between 250,000 to a million people were 2.6 percent more costly and those located in areas with over a million population were 10.9 percent more costly. They determined that costs increased, but less than proportionately, with hospital bed size. Since major teaching hospitals have higher measured case mix indices, are located in SMSA's with high wage rates, are located in the largest metropolitan areas and are bigger, these factors will account for much of the higher observed Medicare operating costs per case in these hospitals.

Nevertheless, controlling for these factors, Medicare operating costs per case increased approximately 5.79 percent for each .1 increase in the number of residents per bed and it is this relationship that has been labelled the indirect cost of teaching.

Before continuing, it is necessary to stress that the estimate of the "indirect costs of teaching" is obtained statistically. The estimated relationship between Medicare operating costs and residents per bed will depend on what other factors are controlled for and how well they are measured. It is likely that some of the effect on costs attributed by the statistical analysis to residents is due to other variables which are not included in the analysis.¹² One indicator of the sensitivity of the estimated size of the indirect teaching adjustments to the nature of the control variables can be given here. If the analysis of Medicare operating cost per case is repeated excluding bed size and SMSA size as control variables and using a simple urban/rural split, then the estimated relationship between costs and each .1 increase in residents per bed increases from 5.79 to about 9 percent. Some of the factors that may cause the measured association between operating costs and residents to be biased upwards are now examined.

1. **Errors in the DRGs.** The Medicare Case Mix Index used in the analysis was based on data that had been reported to HCFA in 1981—the 1981 MedPAR file. The diagnostic information reported to HCFA was often flawed,¹³ and research by Pettengill and Vertrees indicates that errors in patient classification tend to compress the estimated values of the individual hospital case mix indices.¹⁴ Thus the measured index of a hospital with a costly case mix is likely to be too low relative to its true value while the measured index of a hospital with a much less costly mix of patients will be too high. If the case mix indices of the teaching hospitals, particularly those with large teaching programs were underestimated, then some of the effect on operating costs that was in fact due to case-mix would be attributed to the resident to bed ratio.

It appears in fact that the case mix indices of many

of the large teaching hospitals were underestimated.¹⁵ Hence, if the analysis were to be repeated today, using more accurate data, the estimated statistical association between Medicare operating costs and the resident to bed ratio should decrease.

2. DRG prices: The current set of DRG prices (or relative cost weights) are derived using an algorithm developed by HCFA. To set prices, HCFA estimated the average cost of each DRG by adjusting the average billed charge for each DRG with information from the hospital cost reports. Essentially ancillary costs were distributed across the DRGs on the basis of charges adjusted by departmental cost to charge ratios, and routine and special care costs by their length of stay. The data bases used to calculate these prices were the 1980 Medpar File and the 1980 Medicare Cost Reports.

It is very likely that the relative prices calculated by HCFA are compressed. In other words, the prices of the high cost DRGs are low relative to the actual cost while those of the low cost DRGs are likely to be overpriced.¹⁶ Three factors contribute to this compression. First, there is, as noted above, significant error in the MedPAR data base—thus the estimated cost of a given DRG will be based on patient charges for both patients who are accurately coded in a DRG and those who are inaccurately coded. Second, the price setting algorithm implicitly assumes that the per diem routine costs and per diem special care costs are the same for each DRG. However, to the extent that the level of routine and special care costs are affected by case-mix, this algorithm will lead to a relative underpricing of the high cost DRGs (and overpricing of the low cost ones).¹⁷ Finally, there is considerable anecdotal evidence that, at least until recently, hospitals subsidized the prices of specialized high cost procedures.¹⁸ To the extent this practice is pervasive, the adjusted cost for the truly high cost patients who are likely to use high cost services will be set relatively low.

The compression of the DRG prices will lead to an underestimation of the size of the case-mix index in hospitals that treat a high proportion of high cost patients while it will lead to an overestimation of the size of the case mix index in hospitals with proportionately more low cost cases. Again if the magnitude of the case mix indices of hospitals with large teaching programs are underestimated, then some of the effect on operating cost that was in fact due to case-mix would be attributed to the resident to bed ratio. Much of the source of error in the DRG prices should be eliminated if the prices are reestimated using more accurate diagnostic codes.

3. Limitations in the DRGs: The DRGs classify patients into one of 468 groups for payment purposes. Data used to group patients into DRGs are restricted to information that is readily available on the hospital discharge abstract.

Grouping variables include principal diagnosis, surgical procedures, complicating or comorbid condi-

tions (based on secondary diagnoses), age and discharge status. Some of the DRGs are collections of more homogeneous patients than other DRGs. The coefficient of variation (a rough measure of homogeneity) of patient lengths of stay or charges within DRGs ranges from under .4 to over 1.6 with the coefficients of variation of the surgical DRGs being considerably smaller than those of the medical DRGs.¹⁹ While part of the observed variation is attributable to coding errors and part due to varying levels of inappropriate care, some of it is due to the fact that some DRGs are aggregations of patients with very different resource needs. The less homogeneous the patients are within a given DRG, the more likely it is that hospitals will not get a random mix of patients within that DRG.

A number of people, including the Secretary in the *Report to Congress* and the Senate Finance Committee, argue that the teaching hospitals do not serve a random sample of patients within each DRG. They argue that teaching hospitals are likely to attract the sicker and more severely ill or the more difficult to diagnose patient. Research by Horn and by Knaus, et al provides support to these arguments.²⁰ However, research by Coffey and Goldfarb suggests that, based on disease staging, teaching hospitals do not treat a more severely ill patient population. To the extent that the DRGs fail to classify patients accurately and to the extent that the more costly patients within a DRG are treated by hospitals with large teaching programs, then some of the effect on operating costs that is due to patient mix will be attributed to the number of residents per bed.

4. Factor Pricing: The level of hospital costs is affected by the amount that hospital administrators pay for their "factors of production"—nurses, supplies, drugs, electricity and so forth. In the statistical analysis of the factors affecting Medicare costs per case, the only factor price that was taken into consideration was hospital wages—using a single wage index for an SMSA or for the rural areas of a state. However, there can be considerable variation in wages within an SMSA. The wages of workers who work in the central city are often higher than those in the suburban ring. For example, in a study of hospital costs in five metropolitan statistical areas it was found that wages were an average 17 percent higher in the county that formed the metropolitan core than they were in the suburban ring.²¹ Thus, to the extent that hospitals with large teaching programs are more likely to be located in the central city, the estimated effect of residents per bed on Medicare operating costs will be slightly overestimated.

As noted above, labor is not the only factor of production which is used in the production of inpatient services. Food, energy, drugs, and so forth are also used. While some of these products are purchased in national markets, others are purchased locally. Regional price indices for factors of production other than labor are not currently available. However, cost

of living indices published for the major cities indicate that the price of food and electricity vary regionally, with higher prices often found in the Northeast.²³ Given that 39 percent of COTH member hospitals are located in the Northeast compared to 13 percent of nonmember hospitals, the omission of factor prices other than labor may lead to a slight upward bias in the estimated effect of residents per bed on costs, although this bias would be very small.

5. Indirect Teaching Costs: The indirect costs of teaching may be defined as those additional costs that are incurred by a hospital because it is engaged in graduate medical education and because it has a large number of residents directly involved in patient care. These costs do not include the easily identifiable direct costs such as the salaries paid to the teaching physician and the salaries of residents themselves.

The true indirect costs are inherently difficult to identify—which is the reason that statistical analysis is used to estimate them. However, one major source of these costs is the increased use of ancillary services in the provision of patient care. Almost all investigators have concluded that, controlling for the patient diagnosis, more ancillary services are provided in teaching hospitals.²⁴ One study, for example, found that the average charge for patients with congestive heart disease was 14 percent higher in teaching units than in private units with most of the difference attributed to the increased use of ancillary services.²⁵ A second study found that, within the study hospital, service charges were 60 percent higher on the teaching floors than on the nonteaching floors. (The researchers believed that the patients were comparable.)²⁶ Still a third study, which compared patient care patterns in a teaching hospital with those of a nonteaching hospital, found that charges were higher in the teaching hospital with most of the difference being attributable to the greater frequency of diagnostic testing.²⁷ The list could go on.

This increased use of ancillary services is primarily due to four factors: (1) the residents' relative inexperience and the fact that some of the extra testing represents learning by doing; (2) the tendency in teaching hospitals to try to make a more accurate diagnosis for both educational purposes and to satisfy the more academically minded physicians' "need to know" even in those circumstances where treatment will not be modified by the finding;²⁸ (3) the increased availability of state of the art testing facilities; and (4) the fact that very sick patients may be treated much more aggressively in these institutions.²⁹

The increased use of ancillary services is thus highly correlated with the number of residents per bed. However, it must be pointed out that the increased use of ancillary costs will not be directly translated into a proportionate increase in ancillary costs since the marginal cost per test is generally low.

There are no doubt other costs that teaching hospitals incur because they have large teaching programs. These include factors such as more extensive and much more expensive medical record keeping, more complete medical libraries and so forth. In addition, because they have large teaching programs, these hospitals may feel that they are under more pressure to introduce state of the art technology with its higher costs.

These five factors are not the only ones that influenced the 1981 estimated statistical relationship between residents per bed and costs, but they are surely the most important ones. Thus it is likely that, if a better case mix classification system were available, if better cost weights were calculated and if more attention were paid to the different factor markets, the estimate of the association between Medicare costs per case and residents per bed would be less than "5.79" percent. How much less it is hard to say, but it would be surprising if it fell below 5 percent.

The Indirect Costs of Medical Education Considered Further

The term "indirect costs of medical education" has become increasingly murky over time. The discussion above should suggest that there are at least three ways in which this term is used. One is a *concept* which suggests that even after the direct costs of education are taken into account, the costs of providing patient care—to similar type patients—will be higher in hospitals with large graduate medical education programs. The second is an *estimate*. It is an estimate of the relationship between costs and residents per bed after controlling for other factors that are expected to influence hospital costs. The *estimated* relationship of the pure indirect effect of graduate medical education will depend on the other variables included in analysis; both the type of variables and how they are measured.

The third is a payment which is added to the standard DRG payment in order to both pay for the indirect costs of graduate medical education and to compensate for problems with the current DRG classification system. In practice this payment also compensates for some of the limitations in the current method of adjusting for factor price differences across geographic areas. The size of the payment is related to the estimated statistical relationship between costs and the resident to bed ratio. In fact, the estimated relationship is doubled.

Under the current prospective payment system, as noted above, the adjustment is tied to the size of the relationship between Medicare operating costs per case and residents per bed obtained from an analysis in which MSA size, hospital bed size, MSA wages or state rural wages and the Medicare case-mix index are used in the analysis. The payment adjustment is obtained by *doubling* the estimated size of the relationship. With the exception of these payments, the

level of the payment that a hospital receives for a given DRG will depend on its location (urban, rural) and area wages.

The design of the current prospective system and the payment adjustment for the indirect costs for medical education is inherently flawed. It is flawed first because it uses inadequate methods to adjust for differences in the economic environment in which hospitals provide care. In addition it is flawed because it ties the increased payments to teaching hospitals—payments designed to compensate them for unmeasured differences in their patient population—to the number of residents per bed and because the payment adjustment is *higher* than the estimated cost relationship between residents per bed and costs.

The design of the system leads to a somewhat inequitable allocation of Medicare payments among hospitals.

Suppose there is a large community with two 1200 bed hospitals. One hospital has 400 residents in training, while the other has 120. The first hospital will receive 20.8 percent more per DRG than the second although they are probably treating the same kinds of patients and pay the same amount for nurses, etc. On the other hand, two urban teaching hospitals located in the same MSA with the same size graduate medical program will receive the same payment per DRG although the one located in a suburban county probably faces lower labor costs than the one located in the central city.

These flaws, which have led to a large payment to hospitals under the rubric "indirect costs of medical education," are likely to give rise to three quite different kinds of responses.³⁰

First, given the intention of Medicare to limit the overall payments to hospitals, the relative financial advantage of institutions with large graduate medical education programs is likely to be perceived as unfair by other hospitals. Thus, these hospitals are likely to attack the double teaching adjustment in the same way that the Federation of American Hospitals attacked the federal Medicare waivers to the four rate setting states.³¹ The reduction in Medicare payments to hospitals with large teaching programs would be offset by payments to those with none. Recently released data by HCFA is likely to encourage this response. HCFA reported in testimony to the Subcommittee on Health of the Senate Finance Committee that, "Our simulation indicates that approximately \$204 per case would be withheld from all hospitals so that all teaching hospitals could receive an average of approximately \$613 per case for indirect medical education."³² These numbers, however, exaggerate the extent to which payments for indirect medical education affect the distribution of Medicare payments among hospitals for a given Medicare budget. If there were no payments for the indirect medical education adjustment, then the standardized DRG payments for all hospitals—including those

hospitals with major graduate medical education programs—would increase and significantly larger DRG payments would flow to teaching hospitals, though the distribution of the payments among teaching hospitals might be different.

Second, separating the adjustment for the "indirect teaching costs" from the actual DRG rate and paying it as a lump sum makes the payment vulnerable as a source of federal budget savings. Thus it is only a matter of time before there is a pressure not only to reduce the size of the adjustment but also to coordinate the adjustment with federal manpower policies. For example, residents in specialties that are considered to be in excess supply could be eliminated from the count of residents used as the basis for the adjustment.

Third, other things being equal, residents are now a significant source of income. Given that residents salaries are included in the direct medical education pass through, hospitals may have strong incentives to try to increase their number of residents.³³ One way that a hospital can attract more residents is to increase their salaries, and thus it can be expected that there will be upward pressure on such salaries as the market begins to work. (This incentive, however, will be dampened if there is increased price competition among hospitals as a result of private sector initiative such as the promotion of HMOs or preferred provider organizations.)

A significant reduction in the size of the adjustment, however, will not eliminate those problems that generated the doubling in the first place.

The doubling arose because under the Secretary's original proposal, hospitals with large graduate medical education programs would have been disproportionately "penalized." From the perspective of time, it is clear that it is not understood that the reason for their being disproportionately penalized under that proposal was as much due to the failure of PPS to adjust for factor cost differences as it was to the inadequacies of the case-mix classification system. One consequence of the doubling is that the "true indirect costs" of graduate medical education are exaggerated and that the political debate over the issue has become distorted.

Possible Evolution of the Prospective Payment System

In order to rectify some of the problems discussed above, it is necessary to make some changes in the design of the prospective payment system. These changes should make the system more equitable and help promote the efficient delivery of hospital services. It should be noted that many of the steps needed to implement these changes are already on the HCFA agenda.³⁴

The first step is the most obvious one and one that HCFA can be expected to take. As soon as HCFA has at least 6 months of discharge data reported under PPS, it should recalibrate the DRG cost weights and

then recalculate each hospital's Medicare case-mix index. Since the reporting of diagnostic information was meaningful during that time period, the amount of error embedded in the data should decrease. Thus the DRG cost weights should improve and the estimated individual hospital's case-mix index be more accurate. Then HCFA should reestimate the teaching adjustment factor. One would expect that with more accurate case-mix data, the estimated value of the association between Medicare costs and the resident to bed ratio would decrease.

The second step is to modify the structure of the current DRGs. Some of the current DRGs are too heterogeneous to be used in a payment system. In addition, the associated failure of the DRGs to adjust for severity will become more pernicious as the hospital specific component of the prospective payment system is phased out. Two short term possibilities should be explored. The first is to experiment with modifying the current DRG system based on information from other case mix classification systems based on discharge diagnosis such as staging³⁵ or patient management categories.³⁶ Second, the phase-in period would help to alleviate problems due to the classification system only if the actual case-mix of a given hospital were reasonably stable over time. In the long run, a new approach to classifying patients may be desirable. Research on reliable methods of severity measurement and on the development of classification systems that provide more clinically specific categories should be a top priority.

The third step is to improve the method used to estimate the DRG relative cost weights. Particular effort will have to be directed towards methods for allocating the routine and special care costs across the DRGs. (The other two factors that were identified above as causing problems with the current DRG cost weights—errors in patient discharge codes and cross price subsidization—should fall in importance over time as a result of both the Medicare PPS and increased competition among hospitals due to changes in private financing.)

The fourth step is to determine why hospital costs are so much higher in the larger Metropolitan Statistical Areas. As noted earlier, controlling for wages, residents per bed and the Medicare case-mix indices, HCFA analysts found that Medicare costs per case varied significantly with the size of the urban area. They found that hospital costs in urban areas of over a million population were 10.9 percent higher than hospitals located in rural areas; while hospitals located in urban areas with 250,000 to 1 million people, and those in urban areas with less than 250,000 population were 2.6 and .1 percent respectively more expensive. Subsequent research indicated that hospital costs in SMSAs with over 2.5 million people are significantly higher than those of hospitals located in areas from 1 to 2.5 million people.³⁷ Some of this cost differential may be due to unmeasured case mix differences. Most however, is likely to be due to the fact

that the majority of hospitals in larger urban areas are located in the central city portion of the MSA and need to spend more on security and employee wages generally. Whatever the reason, if the size of the urban area is not taken into consideration, then *all* hospitals in those areas will be relatively adversely affected. One way to adjust for those differences, would be to treat each MSA as a separate group for rate setting purposes or to expand the number of locational factors used to set the national rates from two (urban/rural) to possibly 5 groups based on SMSA size. The first approach would be administratively complex while the second would exacerbate the boundary problem (hospitals in one MSA could receive significantly lower DRG payments than hospitals in a slightly larger MSA.) A different approach would be to slow down the phase in period.

A fifth step is to improve the information on factor prices. While HCFA is already engaged in a study to improve the wage data, it should also be encouraged to collect data on other factors of production that are purchased in local areas. In addition, the relevant geographic area used to adjust for factor price differences should be reconsidered. Currently, the MSA is the relevant geographic area for determining wage differences. However, as noted above, wages in the core county are often higher than wages in the counties making up the suburban ring. If this wage differential is not taken into consideration, then hospitals located in the core county will be adversely impacted. The problem of defining the relevant market area for assessing factor price differences is especially serious. The current urban subdivisions are defined as aggregates of counties which are historical political artifacts. (Similar problems exist among and within the rural counties of states.) However the setting of different wage indices for different areas within an MSA would again create a major boundary problem. Two hospitals across the street from each other, one in the suburban ring and the other on the perimeter of the core county, could receive quite different payments for a given DRG.

Thus, there are many modifications that will have to be made in the design of the prospective payment system. The first three steps relate to changes that will have to be made in the patient classification system and the mechanism for setting relative payments. The fourth and fifth steps relate to methods for adjusting for geographic variations in factor costs that depend on location. For Medicare, a national system, at least as much attention must be given to the last two steps as to the first three. One way of underlining the importance of the last two steps is that even if it were possible to develop a perfect classification system and an accurate set of relative prices for the DRGs, hospitals in the large MSA's and in the core counties within the MSAs (many of which are teaching hospitals) would be relatively adversely impacted under a national prospective payment system as currently designed.

Hospitals with large medical education programs would be relatively adversely impacted even if they received a payment adjustment for the "true" indirect costs of medical education.

A satisfactory completion of these steps may be impossible and Medicare may seek methods of delegating the payment decisions. Two separate approaches are feasible. First, the federal government could encourage the establishment of state rate setting programs. In this case the methods for paying hospital care would be determined by the states. Second, Medicare could establish capitated systems for Medicare beneficiaries—in which case the organization responsible for providing services would also be responsible for negotiating with hospitals the amounts to be paid for hospital care. Neither of these approaches solves the problems of how to pay hospitals, but they do decentralize the decision to entities that are more able to take local market conditions into consideration.

In addition to the five steps just discussed, HCFA should undertake a study which compares the variation in hospital costs per admission with the total cost of an illness episode. It is possible that the higher costs incurred by the ancillary-intensive teaching hospital admission are offset, at least partially, by the use of fewer medical services during the illness (e.g., fewer re-admission or fewer ambulatory care services) or by fewer days of restricted activity for the patient. No study has examined the costs of teaching and non-teaching hospitals in light of the patient's total illness costs; such a study is needed and should be on HCFA's research agenda.

VI. Summary and Conclusions

The adjustment for the higher costs of teaching used in establishing the routine 223 limits was a reasonable step to take in 1980. The label attached to this adjustment, however, was misleading. The adjustment took into account not only the higher costs associated with medical education but also unmeasured cost factors that were correlated with the number of residents per bed. The continuation of an adjustment for indirect costs under prospective

payment was also a reasonable step to take in 1983. However the magnitude of the adjustment made in 1983 was less justifiable and of considerably more importance to the hospital industry than the one made in 1980. It was less justifiable because it resulted from a pragmatic decision to double an estimated number, and it was of considerably more importance because the amount of dollars at issue was considerably higher.

The current adjustments are somewhat larger than would be considered equitable when the payment rates for all hospitals are considered together, and they lead to an inequitable distribution of Medicare payments across hospitals, not only between teaching and nonteaching hospitals but also across teaching institutions. However, it must be remembered that the size of the current adjustment is partly a consequence of an initial decision to take only a limited number of geographic factors into consideration in setting the payment rates.

The magnitude of the payments made under the rubric of the indirect costs of medical education is likely to make the adjustment a subject of attack by other hospitals. In addition, these payments are likely to be considered as a potential source of budget savings by the Administration and Congress. Nevertheless unless differences in the types of patients treated and the differences in factor prices in the markets where teaching hospitals are concentrated are taken into consideration, any significant lowering of the resident to bed adjustment may put a disproportionate number of teaching hospitals at significant financial risk. Innovative methods for accounting for these factors must be developed if the prospective payment system is to be sustained. This paper has made some suggestions on how to proceed.

The current experiment in hospital pricing under Medicare and the increase in competition in the private sector represent a radical change in the financing of hospital services. This is an experiment that only America has dared to try. No other country has attempted to develop fee schedules for in-patient hospital care. We are sailing an uncharted sea, and must sail carefully.

FOOTNOTES

1. Federal Register. *Medicare Program; Proposed Schedule of Limits on Hospital Inpatient General Routine Costs for Reporting Periods Beginning on or after July 1, 1980*. Vol. 45, No. 4.
 2. This number was derived from information included in a statement by Henry R. Desmaris, Director, Bureau of Eligibility, Reimbursement and Coverage, Health Care Financing Administrator before the Subcommittee on Health, Finance Committee, U.S. Senate October 1, 1984.
 3. There was an effort to determine whether the higher routine per diem costs in teaching hospitals were associated with a more costly case-mix. This effort was not fruitful because an appropriate case-mix index was not available.
 4. Federal Register. *op. cit.* p. 21584.
 5. Alternatives considered and rejected included paying teaching hospitals the same DRG rate as nonteaching hospitals, making the indirect Graduate Medical Education (GME) adjustment a function of the direct GME pass through payment and setting a flat rate per resident per bed.
 6. Secretary of Department of Health and Human Services. *Hospital Prospective Payment for Medicare: A Report to Congress*. Washington, D.C., December 1982, pp. 47-48.
 7. *Ibid.* pp. 48-49.
 8. The actual estimating equation is:

$$\ln \text{CPC} = 7.32 + 1.011 \ln \text{CMI} + 1.022 \ln \text{Wage} + .579 \ln \text{R} + .119 \ln \text{Beds} + .0007 \text{SCV} + .026 \text{MCV} + .109 \text{LCV}$$

(29.63)
(12.72) (24.43) (.58)
(5.29) (60.67)

$$R = .75$$
- Where
 CPC is the Medicare operating cost per case; CMI is the Medicare case-mix index; wage is the wage index; R is Residents per bed; beds is hospital bed size; SCV is urban area with a population of less than 250,000; MCV is urban area with a population of 250,000 to 1,000,000 and LCV is urban area with over 1,000,000 population and ln represents natural logarithm.
9. Senate Finance Committee Report. *Social Security Amendments of 1983*. Report No. 98-23. Washington, D.C. March 11, 1983 p. 52.
 10. Department of Health and Human Services, Health Care Financing Administration. "Medicare Program: Prospective Payments for Medicare Inpatient Hospital Services, Interim Final Rule with Comment Period." *Federal Register*, Thursday, September 1, 1983, p. 39778.
 11. These results are given in footnote 8 above.
 12. The reason for this is quite technical. Statistically, if there is a variable that is excluded from the model that affects hospital costs, and which is also directly related to one of the variables in the model, the coefficient of the included variable will be biased upwards to include the effect of the omitted variables.
 13. The Institute of Medicine estimated that approximately 20 percent of the records in the file used by HCFA to construct the case-mix index had an erroneous principal diagnosis at the DRG level. Institute of Medicine. *Reliability of Medicare Hospital Discharge Records*. National Academy of Sciences. NTIS. PB 281680, November 1977.
 14. J. Pettengill and J. Vertrees. "Reliability and Validity in Hospital Case-Mix Measurement." *Health Care Financing Review* 4 (2), 1982: 101-127.
 15. Personal Communication, James Bentley, Department of Teaching Hospitals, AAMC.
 16. Judith R. Lave. "Note on the Compression in the HCFA DRG Prices." Unpublished paper, University of Pittsburgh, 1984.
 17. Work by Fitzmaurice indicated that routine per diem nursing salaries, a major component of routine costs per day, are significantly related to the Medicare case-mix index. See M. Fitzmaurice. "A Statistical Analysis of the Medicare Routine Nursing Differential." *Health Care Financing Review*. 5 (1) 1983: 45-64. Additional evidence on this issue is presented in J. Thompson. "The Measurement of Nursing Intensity." *Health Care Financing Review*. In press.
 18. Office of Technology Assessment. *Diagnosis Related Groups and the Medicare Program*. Implications for Medical Technology. Washington 1983.
 19. Unpublished data. Bureau of Data Management and Strategy. HCFA.
 20. S. Horn. "Measuring Severity of Illness: Comparisons Across Institutions." *American Journal of Public Health*. 73(1), 1983:26-31. E.A. Draper, D.P. Wagner, and W.A. Knaus. "The Use of Intensive Care: A Comparison of a University and a Community Hospital." *Health Care Financing Review*. 3(2), 1981:40-64.
 21. R. Coffey and M. Goldfarb. "DRGs and Disease Staging for Reimbursing Medicare Patients." Working Paper. National Center for Health Services Research, 1984.
 22. J.L. Ashby. *The Inequity of Medicare Prospective Payments in Large Urban Areas*. District of Columbia Hospital Association. September 1984.

23. J.R. Lave. "Hospital Reimbursement Under Medicare." *Milbank Memorial Fund Quarterly*. 62(2), 1984:251-268.
24. The one exception is a paper by Becker and Sloan which reported no difference in the use of ancillary services between teaching and nonteaching hospitals. See, E. Becker and F. Sloan. "Utilization of Hospital Services: The Roles of Teaching, Case-Mix and Reimbursement." *Inquiry*. 20(3), 1983:248-264.
25. M.L. Garg et al. "Reimbursing for Residency Training, How Many Times." *Medical Care*. XX(7), 1982:719-726.
26. E.W. Martz and R. Plakowski. "Educational Costs to Hospitalized Patients." *Journal of Medical Education*. 53(May) 1978:383-38.
27. S.A. Schroeder and D.S. O'Leary. "Differences in Laboratory Use and Length of Stay Between University and Community Hospitals." *Journal of Medical Education*. 52(5), 1977:418-420.
28. D.B. Reuben. "Learning Diagnostic Restraint." *New England Journal of Medicine*. 310(9), 1984: 591-593.
29. A. Garber, V. Fuchs and J. Silverman. "Case Mix, Costs and Outcomes." *NEJM*. 310(19), 1984.
30. Some of these same issues are described in M.E. Whitcomb. "The Federal Government and Graduate Medical Education." *The New England Journal of Medicine*. 310(20), 1984:1322-1324.
31. Federation of American Hospitals "Potential Inequities of Medicare Waivers" Statement. No date. Washington, D.C.
32. Henry R. Desmaris. *op cit* p. 8.
33. J. Newhouse "Two Prospective Difficulties With Prospective Payment for Hospitals, or It's Better to Be a Resident Than a Patient With a Complex Problem." *Journal of Health Economics*. 2(3), 1983:269-274.
34. S. Jencks et al. "Evaluating and Improving the Measurement of Hospital Case-Mix." *Health Care Financial Review*. Annual Supplement. 1984 in press.
35. J.S. Gonnella, M.C. Hornbrook and D.Z. Louis. "Staging of Disease: A Case Mix Measurement." *JAMA*. 1984.
36. W. Young et al. "Hospital Case Mix: Development and Implementation." Health Care Research Department, Blue Cross of Western Pennsylvania. Pittsburgh 1983.
37. G. Anderson and J. Lave. "The Costs of Teaching Hospitals." Work in Progress.

Mr. WAXMAN. Thank you very much.
Mr. Sillen.

STATEMENT OF ROBERT SILLEN

Mr. SILLEN. Yes; my name is Robert Sillen. I am the executive director of the Santa Clara Valley Medical Center in San Jose, CA. I also served as the chairman of the California Association of Public Hospitals, which represents the 21 largest county hospitals in the State of California.

I would add that there are only 32 of us left. There were some comments this morning about the viability of hospitals in 1965 when Medicare and medical came into existence, there were 65 county hospitals in California. Now there are only 32. I suspect if the direction in terms of Federal and State policy remains on the same course. There will be fewer than that within a very short period of time.

As well, I represent the National Association of Public Hospitals which represents about 55 or 60 of the largest public teaching hospitals on a nationwide basis.

I am going to take a little different approach in terms of my discussion today and not focus on graduate medical education, per se. That is the importance of the production of additional physicians, et cetera, and teaching programs for the educational process, per se. I think if I can make for just a couple of basic points with this committee, that would suffice.

The first point I would make is our teaching programs for us is not a question of medical education, per se. teaching programs is how we provide services to the indigent. So if there is any question as to the impact on indigent care of continued cutbacks in Medicare, be assured from me that the impact will be there; it will be

negative and disastrous is probably too strong a word to use because one immediately reduces his credibility. But the horror stories in fact will develop. You will know about them, and as elected officials ultimately they will be laid at your feet, after they are laid at the feet of my board of supervisors, of course.

But clearly I think one cannot look at the issue of medical education and the teaching passthroughs, et cetera, without putting it in the context at least of public hospitals as well as the teaching hospitals of the other things that have happened in terms of Medicare and Medicaid and other kinds of reimbursement policies.

Consider, please, subsidies for the care to the unsponsored poor falling increasingly out of step with demand. There are now some 35 million Americans who are uninsured and increasingly come to the doorsteps of your local public hospital.

Competitive forces which have been stimulated by BPS and Medicare policy, as well as other kinds of policy at the State level and the private insurance industry—competitive forces are still finding an increasing shift of unprofitable patients to our public facilities.

There is no magic about having money in the hospital business. One of the first things you do is you do not take care of patients who either cost a lot or who can't pay or for whom nobody else will pay. It is just like operating a local grocery store. You don't give away your apples and think that you are going to remain a business too long. It costs us money as well to provide this care, and unprofitable patients are coming to our doors in increasing numbers.

Increasingly inadequate and in our instance in California, MediCal, reimbursement in terms of rates and coverage for both inpatient and outpatient. I would stress both inpatient and outpatient care. There was some discussion about this earlier today, and some discussion of financial incentives. To me, there is no magic about financial incentives. You provide them, you get what you want. If you can decide what you want—not the personal views, of course—then you go out and you buy it. We proposed legislation in California last year whereby the request of the MediCal schedule of maximum allowances on the outpatient side would be increased significantly because it is less costly care.

The idea, obviously, is to try to keep patients out of the hospital. It will provide better access and it will help those of us disproportioned providers be able to keep our doors open and provide meaningful access to the poor and to the elderly. It went through the legislature and it was vetoed by the Governor. Not unsimilar to some things that happen in Washington.

Uneven, inequitable impacts of national rates under Medicare PPS Program, combined with a potential freeze—or I would almost say the freeze on DRG—reimbursement and loss of capital pass-through, et cetera, et cetera. All of these things combined together, especially given the fact that the administration absolutely refuses to date, despite the efforts of this committee, which I commend, to recognize the needs of the disproportionate share facilities.

If anybody needs to be informed about how disproportionate we are, considering that the 31 county hospitals in the State of California constitute 5 percent of the total hospitals, and only 11½ per-

cent of the beds we carry 52 percent of the bad debt and charity care for the entire State, all on the shoulders of those 31 hospitals.

We are disproportionate in terms of case mix. Again 5 percent of the hospitals, 11½ percent of the beds. We do over 33 percent of the burn care in the entire State. We do over 20 percent of the coronary care in the entire State. We do over 60 percent of the hospital-based outpatient clinic visits in the entire State. Five percent of all the facilities do over 60 percent. Why? Because you lose on every patient and you can't make it up in volume.

You have heard that in different kinds of terms this morning. It is bad business from an economic point of view, taking care of poor folks—it is very simple. There is no magic to it whatsoever, so long as we have continued cutbacks, yet that is what the business of the public hospital is.

I don't know how they will remain in business, quite frankly, because it appears as though most reimbursement policy, both private and public, doesn't really care about that. If that sounds too harsh, it may be; but the reality is that the continuance of these cutbacks makes it increasingly impossible for us to continue providing any access to the poor which the private sector don't want.

I used to be a lot more critical of the private sector than I am now, but everybody has to stay in business if we are going to this competitive marketplace approach. Again, there is no magic to it. What one has to do is set out your market, pick out your winners, pick out your losers, and your losers are your local public hospital as long as it's there, and that's the way the game is played in terms of the hospital industry.

I think teaching hospitals, both public and private alike, have taken on the role of indigent care far in excess of your community general private hospital, and that is why I think the medical education passthrough, the medical education reimbursement is so important to us.

Santa Clara Valley Medical Center where I work, will lose if these policies go through, as proposed by the President. \$1,600,000 next year on our bottomline. We cannot cost-shift that to private patients because we don't have a lot of private patients. Public hospitals in the State of California, their patient population consists of maybe 7-percent private patients. It is becoming increasingly difficult to cost-shift in any case because the private insurers have caught on to that. In their view, it is unfair, but that is still possible, except in the public hospital, with only 7-percent of your business privately insured, you can hardly cost-shift to any degree to keep your doors open.

So for us, I think bringing it back to the medical education, which again I would suggest cannot be taken out of context with whatever else is going on, for us we cannot provide the burn care, the spinal cord injury care, the neonatal intensive care, the outpatient ambulatory care. In my counting, there are 15 hospitals in my county. Our hospital alone provides 35 percent of the hospital-based ambulatory care in that entire county. One hospital. We have three satellite clinics, all located in the wrong, if you take a business attitude, neighborhood. The lower income neighborhoods, the minority neighborhoods, the neighborhoods where there is no access to medical care. And from a business point of view, I guess

we would have to conclude we are pretty stupid. But somehow we are in the business of providing access to those people who do not have access in the private sector, and we are losing immense amounts of money by doing that.

As the cutbacks continue and as the situation gets worse, which this year I think will be the first year we have maintained our open-door policy in Santa Clara County, we take all patients regardless of their ability to pay, we bill them all, we don't forgive anybody their debts unless they qualify for no payment on a sliding fee scale that we have developed. It is not a giveaway program, but it is a reality that these are patients who need care. Patients do not come to our facility for elective types of procedures. 58 percent of our admissions are emergency admissions, there is no choice. My full-time medical staff is on salary. They are employed, they are county employees. They don't make the fee-for-service money that is made in the private sector.

The only reason I have a quality medical staff and have quality services at Santa Clara Medical Center is because of the presence of the Teaching Programs. If I didn't have the teaching programs, the milieu, the environment, the excitement, the kinds of specialty services or those teaching programs we provide, I couldn't get a medical staff. Because there is no surgeon who is going to come to my facility and take a salary that I am paying compared to the two, three, four times that that surgeon can make in the private sector.

Why do they come there? They're either fools or they have other objectives. I think they have other objectives, and part of that is the Teaching Program.

I think I will stop. Thank you.

[The prepared statement of Mr. Sillen follows:]

Testimony

Robert Sillen

Executive Director, Santa Clara Valley Medical Center,
Chairman, California Association of Public Hospitals, and
Member of the Board, National Association of Public Hospitals
before

The House Commerce Committee -
Subcommittee on Health & the Environment
April 3, 1985

Mr. Chairman, members of the Committee, I am Robert Sillen, Executive Director of the Santa Clara Valley Medical Center, the fourth largest county facility in California. I also serve as Chairman of the California Association of Public Hospitals (CAPH), representing 21 of the State's largest county facilities, and serve as a Board Member of the National Association of Public Hospitals (NAPH).

I appreciate the opportunity to join you today to share some observations that may help you to understand the unique ramifications of federal medical education policies on the "safety net" institutions I represent, and most importantly, on the vulnerable populations we serve.

I would like to cover three areas:

- The interdependence of teaching programs and maintenance of high quality health services for the sponsored and unsponsored poor that are served in public facilities;
- The contribution public facilities make to training health professionals, particularly in the primary care specialties; and
- The unique services rendered and access to the poor provided by public facilities that may be compromised should medical education support be reduced.

In addition, I am submitting for the record some detailed information on Santa Clara Valley Medical Center, which illustrates in greater detail many of the points I will cover today.

The Critical Intersection of Education and Service Objectives

Many other witnesses before you today can speak much more eloquently about the need for continued support of medical education per se. I would like to focus my remarks, instead, on the impact of teaching support on the provision of indigent care - an objective which is typically a third-or fourth-ranking priority in the university environment, but is of primary concern in my institution, 18 of CAPH facilities in California, and in approximately 39 NAPH Member facilities nationwide that participate actively in graduate medical education programs.

The issue is, at its core, quite simple: without our teaching programs, we would not be able to attract or retain the high quality medical staffs that enable us to meet a growing proportion of needs for both the sponsored poor (Medicaid) and particularly the unsponsored poor.

Only through the affiliation of our larger facilities with university training programs have public facilities been able to run the cost-effective, quality programs which constitute an acceptable safety net for the poor of our urban areas. Please note that our facilities are over 50% older than our private sector counterparts and our costs per inpatient day are 16% below those of private facilities. Add these resource limits to local political dynamics and one could see that it would be virtually impossible to hire the medical staff required to meet the complex service demands of our patients. Perhaps, most important, many of our medical staffs are full-time employees of our institutions and earn one-half or less the income of their private sector counterparts, despite the more demanding caseloads and complex case mix of the patients they serve.

Although we obviously support the long-term training objectives of the universities with whom we affiliate, our concerns are much more concrete and immediate. With:

- subsidies for care to the unsponsored poor falling increasingly out of step with demand;
- competitive forces stimulating an increasing shift of "unprofitable" patients to our facilities;
- increasingly inadequate MediCal reimbursement in terms of rates and coverage for both inpatient and outpatient care;
- the uneven, inequitable impacts of national rates under the Medicare PPS program, combined with a potential freeze on DRG reimbursement and loss of the capital pass-through; and
- the continued unwillingness of HCFA to recognize the unique needs of "disproportionate share" facilities;
- the potential loss to California's counties of some \$280 million in revenue sharing funds, which in many counties are entirely earmarked for health services; and
- negligible opportunities for cost-shifting with only seven percent of our patients covered by private insurance,

it should be of no surprise how deeply concerned our institutions are regarding the potential reduction in direct and indirect teaching support under Medicare.

There is no margin, no ability to painlessly accommodate reductions of the magnitude that would result from the proposed reductions. NAPH data indicate that the direct and indirect teaching adjustment now contribute an average of \$1.6 million a year to our teaching facilities, a potential loss that would require immediate and substantial service reduction.

It is important that we eradicate a misimpression that public teaching hospitals are inefficient, costly institutions. Quite to the contrary, as noted above, California's county facilities are now almost 16 percent less costly on a per inpatient day basis than private facilities. In spite of increased patient acuity, as reflected in our stressed special care units, our lengths-of-stay continue to decline, down almost 7.5 percent in 1984, compared to 1983.

This record of efficiency sounds impressive, and to the payors, it is indeed good news. However, there are limits. The federal government, as a prominent payor which has benefitted from our long record of economy, must come to understand that, while there may be inexpensive lunches, there are no free lunches. The Reagan Administration, not withstanding, ketchup is not a vegetable. And two-tier medicine, where the second tier is qualitatively different from the mainstream, is not a defensible position. To adapt an old saying, you can't lose money on every patient and hope to make it up in volume!

This Committee, through its consistent support for "disproportionate share" hospitals, has provided critical leadership to the field regarding the need to tailor our cost reduction policies to the unique needs and functions of these facilities. Unfortunately, there are other parties, both in HHS and in the States, who have been much less sophisticated and sympathetic. Thus, federal support for medical education takes on importance that it might otherwise not have.

Public Facilities' Role in Medical Education

While the concentration of interns and residents in California's public facilities is less pronounced than in university institutions, public facilities do serve as the training site for some 1813 interns and residents, 38 percent of those reported by California facilities. These trainees constitute a .23 resident to available bed ratio. NAPH national data indicate an even higher .29 resident to bed ratio, among the highest in the country. NAPH member hospitals train some 6,600 house staff per year or 170 per hospital. These interns and residents constitute 10% of all house staff trained nationwide.

Of significance, particularly to the jurisdiction of this Committee, is the relatively greater concentration of public hospital training programs on the training of primary care residents. Some 50 percent of California's public facilities' total interns and residents are being trained in family practice, general practice, pediatrics, obstetrics, gynecology and internal medicine.

A comparison of the proportion of the total operating costs devoted to education is also interesting. Of the 19 county facilities with sizeable teaching programs, from one percent to eleven percent, or an average of 5.5 percent, of operating expenses are dedicated to teaching, a figure which includes interns' and residents' salaries, plus other instructional costs. Comparable analysis of university costs associated with teaching show that only 4.4 percent of costs are dedicated to teaching, yet 12 of these costs are offset by explicit education subsidies.

What is at Stake?

The service mix of public facilities spans the range from the least expensive outpatient care to costly high tech tertiary services. For example, California's public hospitals comprise only 5 percent of the State's facilities and only 11.5 percent of the beds, yet they provide over 32 percent of all burn care, almost 25 percent of all rehabilitation care, and almost 20 percent of all coronary intensive care statewide. At the opposite end of the spectrum, California's county facilities provide an astounding 60 percent of all hospital-based clinic services. This major outpatient commitment, which countless studies have shown to be the most highly correlated with financial distress, reflects the public sector's efforts to compensate for the increasing barriers to private care for both the unsponsored and sponsored poor.

The patient mix of public facilities is a profile of those deemed undesirable by private providers. Again, with only 5 percent of hospitals and 11.5 percent of beds, California's public facilities provide over 27 percent of hospital services to Medi-Cal beneficiaries. Even more striking is the concentration of services for the unsponsored poor in public facilities. Conservative analyses of the most recent data suggests that this 5 percent of the State's hospitals shoulder 52 percent of the charity care and bad debt reported by California facilities.

Public facilities have developed this unique service and patient mix because of the inability or unwillingness of the private sector to provide unprofitable services to unprofitable patients. Loss of this institutional capacity, in the past, would have imposed significant access barriers on those least able to negotiate them. In the present climate, where PPS is combining with Medicaid constraints and private sector price discounting to impose potentially serious limits on the healthy "margins" of private hospitals, significant cutbacks in or closure of public systems will result in absolute barriers to care.

Already, California's private facilities have reversed their pattern of increasing losses. By the third quarter of 1984, they had begun to decrease their revenue deductions from prior year's levels, reflecting the increasing shift of poor patients to public facilities.

Never has preservation of the safety net been so critical:

- critical to the patients we serve;
- critical to protection of the bottom line of private facilities; and
- critical to continuation of the competitive experiment in which we are engaged.

Protection of the teaching support programs represents just one of several components in an effective "safety net" survival strategy. I cannot tell you that loss of this battle will lose the war. Few facilities may close as a direct result. However, one cannot ignore the context in which these proposals are being made. Unless "reform" policy is undertaken with a sensitivity to the compound benefits of teaching support in public facilities and the cumulative negative impacts of the multi-payor deficit reduction program imposed on us, I can provide the Committee no assurances about maintenance of our programs.

Santa Clara Valley Medical Center
San Jose, California

To illustrate these concerns and the critical importance of teaching programs to the provision of indigent care at public hospitals, I would like to review for you the experience of Santa Clara Valley Medical Center (VMC), the institution where I am the Executive Director.

VMC is a 617 bed, licensed acute care teaching facility owned and operated by the County of Santa Clara in California and affiliated with the Stanford University School of Medicine. As the only public hospital in a County of 1.3 million residents, VMC plays a unique and critical role in its community.

- VMC is an important regional provider of tertiary care services:
 - Regional Burn Center
 - Nationally recognized regional Spinal Cord and Head Injury Rehabilitation Center
 - Pediatric Intensive Care Unit
 - Regional Tertiary Neonatal Intensive Care Unit
 - Regional Poison Control Center
 - Paramedic Base Station Hospital
 - Comprehensive Emergency Department
 - Regional Air Medical Transport Service
- VMC provides extensive primary and specialty ambulatory care services through its main outpatient clinic and three satellite primary care clinics. In FY 1983/84, these clinics provided over 180,000 patient visits, representing over one third of all hospital based clinic visits in the county, (excluding the Kaiser system).
- VMC operates the County's only 24 hour comprehensive emergency service with in-house capability in all major medical and surgical subspecialties. In FY 83/84, the ER provided over 60,000 visits, overwhelmingly, more than any other hospital in the County.
- VMC is the major provider of care to Medi-Cal (Medicaid) beneficiaries in the County and one of the top ten highest providers in the entire state. Over one-third of the Medi-Cal population in the County depends on VMC for inpatient and ambulatory care services.

- VMC is the sole designated provider of indigent care services in the County. Through its long standing "open door" policy, VMC provides high quality care to all regardless of their ability to pay.

As a result of its service mission, Federal, State and County funded programs account for over 75% of VMC's total patient population. Without adequate financial support from these programs, VMC could not possibly meet its service mission to indigent and publically assisted patients. But it is important to realize that a significant part of this support comes by way of VMC's participation in graduate medical education programs. To put it simply, VMC could not provide the high quality and level of services it now provides to its indigent and publically assisted patients without the continued support of these teaching programs.

These programs play a significant role in VMC's delivery of primary care services in its ambulatory clinics, as well as providing support to the inpatient units. Currently through its affiliation with the Stanford University School of Medicine, VMC participates in 13 training programs encompassing 57 resident, housestaff positions.

	<u>VMC Resident Positions</u>
Anesthesiology	9
Dermatology	2
Neurological Surgery	1
Neurology	3
OB-Gyn	8
Ophthalmology	1
Orthopedic Surgery	5
Otolaryngology	3
Pediatrics	9
Physician Med and Rehab	6
Plastic Surgery	1
Radiology-Therapeutic	8
Urology	<u>1</u>
TOTAL	57

In addition, VMC operates four graduate teaching programs independently, with 57 resident positions:

	<u>VMC Resident Positions</u>
Transitional Year	8
Internal Medicine	34
Pathology - Anat. Clin	6
Radiology - Diagnostic	<u>9</u>
TOTAL	57

In total, these programs provide VMC with 114 resident, house staff positions, 51 of which are directly in the primary care specialties of internal medicine, pediatrics and OB-Gyn. These residents work closely with our full-time, salaried staff physicians and are essential to maintaining our present level of high quality health services to our indigent and publically assisted patients.

In addition, VMC's participation in graduate medical education is a critical factor in our ability to recruit and retain our full-time staff. These _____ physicians are attracted and remain at VMC because of their commitment and interest in the education of physicians. They are all salaried physicians and are outside the system of perverse fee-for-service incentives that reward physicians for over-utilization. Although their income is only one half or less that of their colleagues in fee-for-service, they remain at VMC because of their dedication to medical education and the stimulating professional environment it creates. Without our teaching programs, not only would it be difficult to recruit new staff members, but I seriously doubt I could retain the high quality professionals that currently provide services at my institution.

You should understand, as well, that with over 75% of our patients publically (under) funded there is no way for us to make up the revenue loss resulting from the President's budget proposal. In Medicare alone, we stand to lose over \$1,600,000 net revenue from the proposed R6 freeze and Indirect Medical Education adjustment factor cutback. Given that there is virtually no other revenue source to be used to offset this loss, I will have no option but to reduce services. Due to the nature of the patient population served by my institution this means that the richest of the rich and the poorest of the poor will lose again and the safety net may not be safe anymore.

Mr. WAXMAN. Mr. Minogue.

STATEMENT OF WILLIAM F. MINOGUE, M.D.

Dr. MINOGUE. Mr. Chairman, Mr. Bilirakis, I appreciate the opportunity to come before you today. My name is William Minogue. I am the president of the Association for Hospital Medical Education, representing the Community of Teaching Hospitals in this country. Of the 7,000 or so acute care hospitals nationwide, about 1,300 of them are teaching hospitals, and somewhere around 1,000 we would classify as community teaching hospitals having a mission that might be in a very rural county, in a town, in an entire State, or even interstate in scope.

Our hospitals range in size from approximately 200 beds to as high as 1,200 beds. The larger ones include Methodist in Indianapolis, Orlando Regional Medical Center, Henry Ford Hospital and Hartford Hospital, on the large side. In my State of New Jersey for example, the Hunterdon County Medical Center, very much studied as to how to put health care in a rural county has a family practice residency standing alone. That is the other end of the spectrum.

We train about 60 percent of all the residents in training nationwide, and 75 percent we estimate of the primary care physician. Graduate medical education is our focus, less so undergraduate or medical students and of course, the continuing education of our practicing physicians.

We feel that graduate medical education turns a successful student into a competent physician, and is a vital part of the cycle of training physicians.

All but one or two States seem to recognize that by the fact that a requirement of licensure is at least 1 year of graduate medical education.

You have heard repeatedly today that the quality of these programs is well assured in the private sector through the accreditation process and through various national and State board examinations.

More recently, internal medicine, with so many subspecialties, has begun to survey subspecialty training programs and it is estimated that approximately 25 percent of the existing programs may not survive that scrutiny. This will improve the quality and reduce the number of subspecialty trainees.

I would first like to address the manpower issues, and then financing.

There is probably an excess of physicians in the pipeline, or certainly will be early in the next decade. Is that good or bad? I submit that we should not hastily stop this production in the interest of keeping the competitive forces alive. We are seeing our graduates signing on into HMO's, urgent care centers, and practices at amazingly low salaries. Not a heck of a lot more than what they're paid as residents. And recent information would indicate with the aging of the baby boom population, the care of the elderly around the year 2010 will require, in fact, more physicians.

So again hasty solutions or meat ax approaches to this, without any sort of physician manpower plan in this country we think would be foolhardy.

I would like to address this elusive medical marketplace, in spite of the absence of an MBA. The competitive forces are all around us. Physicians are competing with the hospitals and one another at an intense level.

Access to care has increased in many areas, except for some rural sites and the inner city. The prospective payment system has caused additional pressure on both the faculty and the physicians in training. The residents must keep the health of their institutions as well as the health of their patients in mind as they make their rounds and order their tests.

So, believe me, cost containment pressure is constantly at work within the hospitals you have been hearing about today. That formerly was not part of the discussion. It was a bit impure. It was somebody else's problem. The hospital administrator's problem, and so forth. The utilization review of Regulatory Programs under the PRO's is having an enormous impact by keeping people out of hospitals, of promoting same-day surgery and outpatient care and so forth.

The statistics are quite clear that utilization of hospitals, length of stay, and occupancy are down, and continue to go down. So there are some forces at work.

I think such Gatekeeper Programs as the HMO's have great promise. If they continue to grow at the current rate they will deal with the subspecialty problem to some degree. Again, not absolute solutions. The primary physician is the king of that hill, clearly he is the gatekeeper, the only legitimate gatekeeper, I feel, and he in turn has incentive to use less specialists and use less hospitals.

In time, and with enlargement of those kinds of programs, he will be a more respected individual in the medical profession.

I compliment the panel that preceded us, because I think they articulated the deep problem that those specialties are in right now. You will hear from the coalitions and preferred provider impact in your next group. Certainly the fact that a consumer has emerged—namely, industry, who pays most of the health premium—is real and is beginning to affect the medical marketplace.

I would like to think that the students follow first intellectual and medical interests, and hopefully their aptitudes. They follow their mentors or role models but they also follow the dollars. They have to, for all kinds of reasons, not the least of which is the enormous debts they have upon graduation from medical school.

I would like to at least mention the FMG problem. We have talked mainly about the first-year positions. Throughout the 3 to 7 years of graduate medical education, because the FMG's continue on—approximately 18 percent of all trainees, or 14,000 to 15,000 are FMG's. That problem and the recent growth of the offshore medical schools, has worried all of us, and many States have begun to specifically inspect those schools.

My State of New Jersey has a panel reviewing the schools that wish to place students in the State. More importantly, the State Board of Medical Examiners is requiring 3 years of graduate medical education for graduates of foreign medical schools in the

thought that the accreditation and quality of those schools is an unknown, and therefore with 3 years of graduate medical education, our citizens might hopefully be a little safer.

The Federation of State Medical Boards has begun to look very carefully at this on a unified basis. The State licensing boards are beginning to look much harder at the problem, and I think some pressure will be brought to bear, at least in the quality area. Whether that will affect the numbers, I'm not sure.

We do favor some foreign medical graduates as international scholars. We think that is good for the health care of the Third World and underprivileged countries.

We do feel graduate medical education is not the control point if there is to be national policy, rather it is at the intake into medical school. Every graduate of a U.S. school should reasonably expect to find a residency, not always his first choice. And so if there is to be control, it should not be at the graduate education level.

You have heard repeatedly, and we agree, that we all pay for the financing of graduate medical education. It is not a tax on the sick, it is a very broadly based tax, and we all benefit. All 7,000 of the acute care hospitals benefit because we train the physicians who ultimately enter those hospitals, and all citizens benefit.

The direct costs have been talked about so much, and what we recommend is in our written statement. I would say in a very few words that we think the direct costs should be left alone at this point until there is a manpower plan that is rational, that makes some sense. Any sort of freeze, and certainly a freeze at the 1983 level amounts to a cut. I totally agree with the primary care panel that they will be the first out. Family practice is the youngest of the specialties, only about 15 years old. The least well rooted in most academic health centers and also expensive because of uncompensated outpatient care. It will clearly be the first to go.

As far as the indirects are concerned, the severity indices being worked on should be finalized and tested rather than a meat ax approach. We do not have the microsurgical knife that the committee and all of us would like to take out the diseased tissue and leave the viable.

You should not support the mindlessness of just cutting the indirects in half, an admittedly arbitrary number being halved.

In conclusion, we think the cost of graduate medical education is legitimate, that we all pay for it one way or another, that we all benefit, and that many marketplace forces are at work, both regulatory and competitive and that we need a plan. We urge you not to cut now. It takes at least 10 years to build a strong residency. Uncertainty of funding year to year and commitments to residents for 3- to 5-year programs, is just not healthy for any educational process.

I thank you for your time.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Dr. Minogue follows:]

STATEMENT
OF THE
ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION

Mr. Chairman and members of the Committee:

Thank you for the opportunity to testify at this hearing on the financing of graduate medical education.

The Association for Hospital Medical Education (AHME) represents community hospitals involved in the teaching of medical students, residents, interns and practicing physicians. Of the twelve hundred hospitals with graduate medical education programs in the United States, approximately one thousand are non-profit community hospitals. Our member hospitals range in size from two hundred to one thousand two hundred beds. Some of our larger institutions are tertiary care referral centers where the community they serve extends to the state or even nationally. They include such hospitals as Methodist in Indianapolis, the Cleveland Clinics, the Henry Ford Hospital and Hartford Hospital in Connecticut. The smaller hospitals may well serve one community or a rural county and provide only family practice residency training.

Sixty percent of the seventy thousand interns and residents in the United States are trained in our hospitals. Additionally, we train at least three-fourths of all primary care physicians in America. The medical education that takes place in community teaching hospitals focuses first on patient care, with teaching and research as secondary priorities. Education serves the dual purpose of enhancing the quality of medical care and assuring a continuing flow of well-trained young physicians.

The scientific and technological advances in medicine since World War II have served to extend the time necessary to train a competent physician. Following four years of pre-medical education, a student enters medical school and spends his first two years mastering the basic sciences. Years three and four are devoted to the clinical sciences which are taught at the bedside and in the clinics in teaching hospitals. Upon receipt of the M.D. degree a young physi-

cian is not prepared for medical practice. In fact, virtually all states require at least one year of graduate medical education and many require two years. All specialties, including primary care, require a minimum of three post-graduate years. Those requiring the highest degree of mastery of technical skills may extend to seven years. Ninety-five percent of all graduates of American medical schools complete a residency training program.

Research in our hospitals is almost always directed at solving patient care problems. As such, community teaching hospitals are ideal proving grounds for the new science and technology developed in academic centers. Further, clinical trials of new devices, procedures or therapies are frequently best accomplished in community teaching hospitals since their patient populations tend to be more reflective of disease patterns throughout our society.

GRADUATE MEDICAL EDUCATION ISSUES

I would like to share with you some observations about two major issues, physician manpower and the financing of graduate medical education.

Physician Manpower

o Are we training too many or too few?

o Are they maldistributed?

Financing of Graduate Medical Education

- o Should Medicare support Graduate Medical Education?
- o Is the current funding too much, too little or just right?

PHYSICIAN MANPOWER

There is considerable debate over whether we are producing too many physicians. In response to federal policy, the output of American medical schools has doubled in the last decade. In addition, numerous young Americans are training abroad and entering the U.S. physician manpower pool. While there is a general feeling that there will be an "excess" of physicians in the 1990's, there is not agreement that this will be the case in the beginning of the twenty-first century with our significantly increasing elderly population and the health care they will require.

Many economists have despaired of there ever being a competitive marketplace in medicine. Our Association members are already observing a high level of competitiveness. The combination of pressure by the government to reduce costs under the Prospective Payment System (PPS) and the Professional Review Organizations (PRO) and the growth of alternative care systems such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are creating a true medical marketplace in this nation. An abrupt limit on the number of physicians will be counter to these forces.

The federal government has recently moved to make membership in HMOs easier for Medicare recipients. These organizations create incentives for primary physicians and disincentives for the use of specialists and hospital-based care.

We do believe that the government faces an important issue with regard to foreign medical graduates and their entry into the U.S. health care system. We have an obligation to provide training opportunities for the graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME) and the accredited osteopathic schools. We do favor though, opportunities for alien foreign medical school graduates to train in our setting as part of their education prior to returning to their respective countries. Eighteen percent of all residency positions are currently filled with U.S. citizen and alien foreign medical graduates.

The quality of graduate medical education programs has been maintained at an exceedingly high level through the efforts of the Accreditation Council for Graduate Medical Education. In recent years sub-specialty training programs have come under their scrutiny. It is estimated that in the various sub-specialties of internal medicine, twenty-five percent of the training fellowships will not meet the standards and thus be phased out.

A newly prepared Foreign Medical Graduate Examination in the Medical Sciences has raised the standards for entry of these students to that traditionally required of graduates of LCME accredited institutions.

If there are to be controls on the numbers of physicians in training, we believe the control point should be entry into medical school, not graduate medical education. Any abrupt reductions in graduate medical education funding will be unfair to the students currently in our schools. However, since eighteen percent of all residents are foreign medical graduates, there may well be an opportunity to reduce overall funding.

FINANCING

We believe the financing of graduate medical education is a responsibility of all those who benefit, or may at some time benefit from the quality it produces and from the resources it prepares for the future. The current system meets this responsibility, with each payor contributing a fair share through their health insurance premiums. We favor the continuation of this approach. Further, if one wishes to cut back on the number of physicians being trained in this country, a focus on graduate medical education to bring this about is inappropriate. Rather, control should be exercised at the entry point in medical training - entrance to a medical school.

When discussing Medicare's contribution to graduate medical education, it is divided into two components - direct and indirect costs.

Direct Costs - Direct medical education payments are for the salaries and direct support of residents and interns. It is this training in the care delivery setting that converts an individual from a successful student to a physician. At a community teaching hospital, he/she has the opportunity to participate in patient care in a variety of settings both in and outside of the hospital. With the emergence of alternative delivery systems, residents should be exposed to these cost-effective approaches. In addition, the federally mandated prospective payment system and utilization review programs have caused all hospitals, including the nation's teaching hospitals, to insist that their practitioners concern themselves with both the health of their patients and the financial health of their hospitals. As a result, cost containment is now interwoven into the fabric of graduate medical education and will have a significant short and long term impact.

The Administration's proposal to freeze direct graduate medical education payments will have inordinately adverse effects on community teaching hospitals, as many programs are relatively small and

will disappear. As residents and interns are an integral part of the patient care in community teaching hospitals, both quality and access to needed health care will suffer. With inflation at 4.5%, placing a cap on graduate medical education funding will amount to a reduction in the first year. The various proposals to fund only the first or the first three years of residency will inevitably do harm to the specialty training programs. This long term outcome is unacceptable. We favor full direct funding of all accredited primary care and specialty programs while we work together with the government to develop a manpower plan. Meanwhile, the already existing regulatory initiatives of the government and the market forces now in place will partially rectify the problem.

Indirect Costs - Indirect medical education funding is based on a formula of residents to beds and was essentially developed as a proxy to account for the legitimately higher costs associated with teaching hospitals. Until such time as these costs are identified, the administration's recommendations to merely half them is not acceptable. We favor continued development of a severity index such as the one under study by the Prospective Payment Advisory Committee to the Health Care Financing Authority. Until such time as better measures are developed for computing this adjustment, we favor its continuance at a reasonable rate.

Finally, a number of alternatives to the current system of financing graduate medical education are under review. They range from turning the responsibility over to the states, to the medical schools, or to limiting the number of years of federal financial support. We find each of these proposals to have major flaws when compared to the present system. States are in no position to establish training needs as each is only a small part of an overall national system of health care.

CONCLUSION

Our current system for graduate medical education is working and is not in need of major reform. It is but a part of our overall health care system, and over time is responsive to the configuration of that system. Many changes are now occurring in the delivery of health care services. It is only a matter of time before these changes are reflected in our education programs.

Abrupt regulatory intervention without a manpower plan is likely to do more harm than good. On the other hand, withdrawal of government support will also have significant adverse consequences. Recent information indicates that the Medicare program is in better fiscal shape than had been thought. This is in part due to the reduced utilization of the most expensive component of care, namely the hospital, and the impact of various alternative delivery systems. Let us work together to develop a long term physician manpower plan while allowing existing cost reduction programs and changes in the health care delivery system to have their effect.

Thank you for your kind attention and concern.

Mr. WAXMAN. I want to commend each of you for your testimony. It has been very helpful.

Mr. Sillen, let me start with you. Let me explore some things.

You are from a public hospital. Almost all or all your patients are either Medicare, Medicaid or indigent. Is that a fair statement?

Mr. SILLLEN. Yes. My individual hospital probably is a little better off, if you will, because we have about 20 percent or 22 percent of our patients are privately insured patients. They are all in our specialty units, because we are the only game in town. We are the only spinal cord injury center, we are the only burn center in the region. If it weren't for that, people who have choices, privately-insured patients at this point in time do not choose to come to us, but the majority—we have 40 percent MediCal, only 15 percent Medicare. So you can see my concern over the Medicare reimbursement policy—40 percent MediCal, 15 percent Medicare, 20- to 25-percent unsponsored.

Mr. WAXMAN. How much of your teaching staff is in the Residency Program?

Mr. SILLLEN. We have about 60 full-time physicians, full-time, salaried employed physicians. We have 114 residents and interns, 50 percent of whom are primary care specialties.

Mr. WAXMAN. How many of them are foreign medical graduates?

Mr. SILLLEN. None.

Mr. WAXMAN. Why is that?

Mr. SILLLEN. Because we have a quality program and because we are affiliated with Stanford, I think, which helps a lot. As a matter of fact, exactly half of our residents are in fact Stanford residents who do their training at our facility. We deal in surgical specialties

because these rules require that they be university-based. Medicine and most of the other primary care specialists, pediatrics at Stanford as well. It's the quality of the program, really, is what it is. We have tradition, we are known, and people come to our facility because we have been able to maintain the quality of the care.

Mr. WAXMAN. So you take residents who are basically students in graduate medical education and underpay them for what they provide in order to take care of patients for whom you must provide services as a public hospital?

Mr. SILLEN. That is correct.

Mr. WAXMAN. And therefore you stated in your testimony that the Teaching Program to you is really a way or intricately tied to providing care for indigents, particularly the low-income patients.

Mr. SILLEN. No doubt about it. I mean in my terms I guess that I use, I'd say that without teaching programs, we would turn into a 100-bed schlock house county hospital, which nobody is really interested in doing. It would have a significant deleterious impact in terms of the community.

Our bottom line is major portions of our community depend on us. We are it. We are the safety net, we are the provider of last resource, whatever term one wants to use, because they don't have access to the private sector, even though they may live two blocks from a private hospital, or a private physician. So it's us.

And teaching programs. As I said, we are not involved in medical education, per se. That's the University of California's job, that's Stanford's job, the university's job. But for us it is the way that we can provide the services that we provide.

Mr. WAXMAN. Medicare specifically does not factor into the reimbursement payment to take care of the indigent populations that a provider also sees?

Mr. SILLEN. No, they do not.

Mr. WAXMAN. Yet for you it is a real issue, because unless you have money from Medicare which can give you some cushion, you really can't take care of the indigent population that you have, at least in the fashion you are now doing.

Mr. SILLEN. That is absolutely right. If we become—if our whole patient population becomes just the medically indigent, we will do harm in the name of doing good. That's really what it comes down to.

So we have to have Medicare patients and Medicare reimbursement. We have to have MediCal, and neither pay what our costs are. We have to have privately-insured patients, although it's interesting, nobody is competing for my patients. Let's have that understood. The private hospitals are competing for each other's patients. Competition to them is they transfer.

You know, over the last 2 years our number of transfers per year has increased by 400 percent from the private hospitals.

Mr. WAXMAN. That's where the competition is. And hospitals are finding it more desirable to take patients that can pay or someone pay for their services, some insurer pay for their services. Therefore, it seems to me less likely one will opt for your institution because it probably costs more since you have a teaching factor as well. It seems to me a patient would probably choose another institution, unless it is for some specialized care.

Why, with that kind of trend going on, would there be fewer public hospitals, rather than more public hospitals?

Mr. SILLEN. I think it really boils down to a pretty much hard core local political dynamic, and that is how much heat can the local elected official take over the whole health care issue. So it becomes relatively convenient in many instances to contract out, to go to investor-owned, to sell your hospital, to get rid of it, et cetera, et cetera. That has happened over the years. There have been several studies done on it, in terms of what the outcome has been. It has been relatively inconclusive. There have been no improvements as a result of that is the general conclusion by the people who studied it at UCLA, as a matter of fact.

But I think that is basically it. In California, local government is mandated very specifically in State law to be the provider of last resort. And so one way or another the local boards of supervisors have to provide that care.

Mr. WAXMAN. In other cases where they don't have a public hospital, they're contracting out for that care with a private hospital?

Mr. SILLEN. Some are, yes. Or else there is no contract, there is no hospital contract. For instance, Monterey County experimented with a MediCal, Medicaid. MediCal experimenting in terms of pre-paying HMO type. It just went belly up 2 months ago.

I am not aware of any successful HMO or prepaid mechanism that has successfully handled the poor population. Kaiser certainly doesn't do it. They basically do not deal with MediCal, because they know they can't make it.

The Access Program in Arizona is well known for its faux pas. The final data is not in yet, but it is very hard to capitate a poor sick population. That is not how you make your money in an HMO. You take well unsick employed people.

Mr. WAXMAN. What would happen if we said, look, teaching medical specialties is one thing, taking care of the poor is another, and we are not going to combine the two?

What would happen if we then said we are going to just separate the two and not say we are going to pay more for teaching institutions but pay for—I don't know—we will pay for indigents. But for those we pay we will pay under Medicaid. We will tell them we don't want you to go to teaching hospitals because it is more expensive. Go somewhere else?

What would be the result of trying to separate those two functions that now seem intertwined?

Mr. SILLEN. I think it would certainly be better than the direction we are headed now. But, I have little faith in it in the long term. One has to remember that the dollar is a prime mover these days in terms of decisionmaking at the institutional level. There are essentially undesirable people out there who are considered socially undesirable by institutions and institutions and physicians do not want those people mixed with those normal patient clientele.

One could say, however, going back to pre-1965 and 1965—what were Medicare and Medicaid in essence, other than a financial incentive to take care of the poor and elderly. That marketplace wasn't working pre-1965. That is why Medicare-Medicaid came into existence. You have to pay to get those people taken care of, be-

cause it is bad business to take care of on your own. They are sick, they need more services. It is a difficult population, basically, et cetera, et cetera.

So now we are going backwards in Medicare and Medicaid, we are going back to some of the same situations. I don't really see it possible to distinctly separate out the teaching from indigent care, although there are nonteaching hospitals who do provide indigent care. Many fewer now than there used to be, and to a lot lesser level. And that is only going to increase—that is the lowering of the level is going to get worse in the future.

Our patient population is increasing. In California the bottom is falling out of most hospital census with the exception of county hospitals, because all those patients nobody else wants now are coming to us in ever-increasing numbers. We are busy. We don't have a shortage of patients. Our occupancy is high, our efficiency on a cost-per-patient-daily basis—we talked about efficiency earlier. The California public hospitals are 16 percent less expensive on a cost-per-patient-day basis than their private sector colleagues.

That sounds good. And, I think we are efficient. One can always become more efficient. But, the down side of that is we are 50 percent older in terms of our physical plants. So, part of the reason for that is there has been no capital investment, and we can't go much longer without the capital investment.

Part of it is just reality. We are into queueing much more than anybody else is. Patient access has been reduced even in our facilities.

Mr. WAXMAN. Mr. King, let me ask you this. If the indirect teaching adjustment must be reduced to some degree, would you prefer it be an across-the-board reduction and the percentage applied to all teaching hospitals, or would you prefer that it be targeted on certain hospitals by size or residency program or other characteristics?

You want us to be more sophisticated than this meataxe approach. How would you do it? Maybe you think we just ought to decide on a figure and then that would be it.

Mr. KING. I think if this is to be done now, you don't have the time for a careful look, although there are some characteristics of some teaching hospitals that deserve more careful scrutiny than others.

There are some 124 hospitals with a ratio of more 0.25 residents per bed. There are over a dozen that have more than 0.75 residents per bed.

I run what I think is a primary and strong teaching hospital. I cannot imagine ratios like that being reasonable.

I think it is both. I would think that initially you probably will have to, if you do reduce the indirect costs, do it across the board. But, I would also ask for some specific guidelines and some explanation as to why those hospitals are so far out of line.

Mr. WAXMAN. Dr. Minogue, do you agree with that?

Dr. MINOGUE. I agree in general, although I think there are several different kinds of teaching hospitals that could be teased out.

I think the kind of hospitals alluded to, the large complex teaching hospitals, some of the 1000-bed hospitals I mentioned, some of them have a great medical student load, for example. Many of my

constituents do not have large medical student load. More fourth-year clerks on electives and so forth.

So, there is not the negative impact of the educational cost in those hospitals.

Some have indigent care heavily and some do not. And then, the smaller hospital that emphasizes mostly primary care is still a different animal.

So simplistic approach as one mathematical formula for the whole nation, I find absurd when a couple of hours of brainstorming, it seems to me, could produce four or five layers, at least, or categories of hospitals to distribute the money more evenly. There have been losers, and we have heard there have been some folks smiling on the way to the bank.

Mr. WAXMAN. We have had questions about foreign medical school graduates. I don't know if your institution, but I know your state has a large number of foreign medical graduates. If we said, look, we are not going to deal to such a great extent with foreign medical graduates, we want to take care of American students, what would be the impact of your State?

Dr. MINOGUE. My State does have, by some 20 percentage points, the greatest number of foreign medical graduates in its training programs.

Mr. WAXMAN. Why?

Dr. MINOGUE. My institution is the mirror image of that, has virtually no foreign medical graduates.

It has to do with a lot of its history. New Jersey had no state medical school until about 12 or 13 years ago. It was an importer of doctors. It really had no history in medical education at the basic level of both the university and the teaching hospital.

It now has a strong and continually strengthening medical school, and it is addressing that issue very hard.

I think that the tremendous foreign medical graduate influx that occurred into that vacuum has been very hard to reverse because the alumni, if you will, of the residencies tend to stay in the hospitals, and the hospital's practitioners tend to be dominated by foreign medical graduates.

So, the state has a particular problem that it is addressing very hard through a legislatively created advisory graduate medical education council. It is looking extremely hard at that issue, the financing issue, the whole manpower issue.

I think it is unique because of a long history of not knowing how to do it better or differently.

Mr. WAXMAN. Are they desirable for residencies because they can serve indigent patients?

Or, are they desirable for residencies for some other reason?

Dr. MINOGUE. That, certainly is a major factor in some hospitals, the inner city hospitals. And, they are not so strong as the hospital in Palo Alto. Some of the hospitals virtually never see a U.S. graduate. They are seeing an increasing number of Americans from foreign schools, and they do rely upon the foreign medical graduate resident as the principal work force in that hospital.

So, I think for that kind of hospital, and there are many of them, some sort of separating of the indigent care from the graduate medical education—I submit many of those hospitals are at the

very low end of the spectrum of quality graduate medical education and should probably not be doing that, but rather should be reimbursed in some way to take care of the patients and not really, frankly, pretend that they are a teaching hospital.

Mr. WAXMAN. Mr. King, he said Palo Alto, is your hospital heavy foreign medical graduates?

Mr. KING. No, we have none either.

Mr. WAXMAN. No.

Mr. KING. No.

Mr. WAXMAN. Thank you very much.

Mr. Bilirakis.

Mr. BILIRAKIS. I hoped to speed things up, that I could tell you, Mr. Chairman that I had no questions. But as time went on here, things came to mind.

Mr. WAXMAN. Well, that is one of the purposes of a hearing.

Mr. BILIRAKIS. I know, but it is 4 o'clock.

Dr. Minogue, you know we talk here about treating indigents, treating the poor. And, you know I know that the real world is that people who are more affluent are going to be able to afford better medical care. But, there has got to be a degree of—I don't know, the word adequate was bandied around earlier, I am not sure what the proper adjective should be there—of care, even for our poor who cannot afford to pay. That should be of an American level, if you will, the type of level that we are accustomed to in this country. Especially for primary care, I would say.

And yet, I know Mr. Sillen made the comment of—I don't mean to put words in your mouth, sir, but basically what I interpreted was that you thought the quality of the FMG, the foreign medical graduates was not of the same quality as those graduating from our schools here.

And then we had various witnesses made the comment that many of our teaching hospitals use foreign FMG's because they are not able to get maybe the better quality residents graduate from American medical schools or words of that effect.

I just wonder, you know are we really helping these poor? Are we really helping the indigents when, in fact, we are shoving FMGs to them when we admit that the quality is not quite there?

The same amount of taxpayers' dollars are going to train the FMG resident that goes to train the American medical school graduate resident, and yet we don't have the same quality there insofar as treating these indigents are concerned, and treating others that come to the teaching hospitals. They are not all indigents, I understand that.

There is something wrong there, I think.

And you made the comment here just a few minutes ago, sir, and I sort of pounded the table there, that maybe there should be a separation there. I mean, why don't we treat something as it really is? If we are going to subsidize with Federal tax dollars, the treating of indigents, why don't we subsidize the treating of indigents?

In other words, why don't we use Federal tax dollars in order to help the poor people to get the proper medical care that is necessary? Why do it through the vehicle, if you will, of paying teaching hospitals to have residents when, of course, some of those residents

are foreign medical graduates—whether they be or whether they not be.

And I guess it comes down to, is it costing the American taxpayer more to do it this way, which is an indirect way of helping the poor people, than it would be if we helped the poor people directly through, whether it be a DRG concept or some sort of a concept of actual treatment of an indigent rather than doing it as adding overhead costs and that sort of thing through residents. It comes down, again I think, to the number of residents that we have in this country and the number of residents that we need—versus the number that we need down to, does the United States need as many individual teaching hospitals as it currently has?

Mr. SILEN, I don't know how far Santa Clara is from Stanford. How far is it?

Mr. SILEN. It is 25 minutes.

Mr. BILIRAKIS. 25 minutes. And you are affiliated with Stanford Medical School?

Mr. SILEN. That's correct.

Mr. BILIRAKIS. Mr. King, how many teaching hospitals, other than the one right at Stanford are affiliated with Stanford Medical School?

Mr. KING. Only the Veterans' Administration Hospital in addition to the Valley Medical Center.

Mr. BILIRAKIS. In addition to Santa Clara.

Is Santa Clara necessary in order to get the job done?

Forgive me, I am certainly not trying to—but, you know, in order to be able to train the medical doctors at—

Mr. SILEN. I'm interested in the answer.

Mr. BILIRAKIS [continuing].—Santa Clara, is a teaching hospital necessary?

Mr. KING. We think so.

Mr. WAXMAN. What else would you say, I guess. You are sitting right next to Mr. Sillen.

Mr. BILIRAKIS. Well, again, the question comes down sir, to you. Do we need as many teaching hospitals as we now have?

Mr. KING. Can I answer your question somewhat differently by suggesting we don't need all the residencies we have in this country. I am closer to your point of view on what to do with the foreign medical graduates. And, we have to face reality.

Some of the hospitals that are being referred to that run teaching programs have always run inadequate teaching programs, and have never had an American medical graduate in their residency programs.

I think it is not excusable to continue those programs any further. Some hospitals are teaching hospitals for the honor it affords and very little else.

I think a tougher look at that probably is appropriate and that might come up with the other side of your answer, that possibly there would be fewer hospitals that could classify themselves as teaching hospitals then.

Mr. BILIRAKIS. And if we as taxpayers paid for our poor, to make sure that they get the proper medical care in a more direct fashion, we could still get that part of it accomplished without hurting the quality of medical care as far as that is concerned, and at the same

time also continue to graduate 17,000, 18,000 whatever the case may be, of medical students out of this country's medical schools who would be adequately trained to get into the medical marketplace.

Isn't that correct?

Mr. KING. I think that is an approach worth pursuing.

Dr. MINOGUE. I would like to respond to that as well. I think that is an appropriate approach. But, unless the steps were taken in the proper sequence, they could be disastrous, because, although we seem to agree in this panel that the quality of many of the hospitals that do largely indigent care, the residency training program is inadequate.

The abrupt removal of that through some sort of focusing on graduate medical education would be a disaster. You have heard the Stanford model which is beautiful.

My hospital is affiliated with Columbia University College of Physicians and Surgeons. Under contract with the Health and Hospitals Corporation Columbia runs Harlem Hospital, and that hospital attracts U.S. graduates. For example they have reduced the infant mortality to the level of almost the suburban population through the efforts of a marvelous programs panel in obstetrics and gynecology.

There is a lot that can be done through education. So, there may be a nugget of something there if medical schools like Stanford and Columbia would take this on as a challenge with the necessary financial help, of course. They can't be asked to do without the dollars to back it up.

So, the quality could be marvelous as it is, I suspect, in Mr. Silen's hospital, and I know it is at Harlem Hospital.

Mr. BILIRAKIS. That is a good answer.

Do you feel, Doctor—you made the comment earlier about the meat ax approach, and whatnot, very well said, of course—do you feel that if that approach is not taken, and it is done through careful study—and again we get down to the definition of what is careful study—and the ad hoc committee, the AMA and the other analysis, that Dr. Heyssel told us about, and whatnot—do you feel that there is enough objectivity among the AMA, the medical schools, the teaching hospitals, that Congress in general, the people could accept some sort of recommendation as a result of careful analysis, to be able to just face up to the fact that we are talking about, for whatever reasons we are talking about great deficits? We are talking about great debts. We are asking basically every segment of the American people to tighten their belts. Do you feel that there is hope that there will be some sort of agreement reached if it is approached in the right way? Or are we basically saying that the teaching hospitals will never be willing to give, that the medical schools will never be willing to give, the AMA won't be willing to give, Congress won't be willing to give and we are right back where we started from?

We are going through an exercise in futility here, just talking about it because it sounds good.

Dr. MINOGUE. I think the objectivity is there. I think there is a sufficiency of fear at this point, too, and concern about what might happen, so that I think that the energy is here, that all of the vari-

ous constituencies you have heard from today could put their heads together with government.

However, I take great offense at one bureau of the government not even talking to another bureau, as we heard this morning, unilaterally playing with the lives of so many people, beginning with the patients and on through these trainees.

Yes, I think you have heard the intelligence around this table today, and you have also heard a great deal of commitment and a great deal of willingness to give.

Mr. BILIRAKIS. Thank you, sir. Thank you, gentlemen. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bilirakis.

Gentlemen, thank you very much for your participation. It has been very helpful. We are looking forward to working with you to see if we can work out some kind of overall consensus.

Our last panel I would like to call forward at this time is Lawrence C. Morris, senior vice president, Blue Cross/Blue Shield Association; Willis Goldbeck, president, Washington Business Group on Health; and Dr. Gerald Anderson, Center for Hospital Finance and Management, Johns Hopkins.

Mr. Morris, why don't we start with you.

STATEMENTS OF LAWRENCE C. MORRIS, SENIOR VICE PRESIDENT, BLUE CROSS/BLUE SHIELD ASSOCIATION; WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH; AND GERALD ANDERSON, PH.D., ASSOCIATE DIRECTOR, JOHNS HOPKINS CENTER FOR HOSPITAL FINANCE AND MANAGEMENT

Mr. MORRIS. Thank you, Mr. Chairman, Mr. Bilirakis.

I am Lawrence Morris, representing the Blue Cross/Blue Shield Association. We appreciate this opportunity to present our views.

We understand the committee will be reviewing the administration's proposal to reduce Medicare expenditures for graduate medical education which would involve freezing payments for direct educational costs and cutting in half the adjustment for hospitals' indirect teaching costs.

We share the administration's concern for Medicare costs and the need to reduce the Federal deficit. However, in our opinion, this will represent only a short term response. It doesn't really address the underlying issues.

We particularly look forward to the forthcoming report by the Department of Health and Human Services on the cost of graduate education.

The education programs at teaching hospitals provide Blue Cross/Blue Shield subscribers with a great deal of patient care, including specialized tertiary services, and we believe that we have an obligation to pay for the cost of those services when our subscribers use teaching hospitals.

In our private business we are able to recognize the reasonable cost of medical education through negotiations with individual health care institutions. We believe that Medicare should continue to passthrough the reasonable costs of graduate medical education,

at least until there are more accurate means of pricing the patient care components that these programs provide.

Ideally, the necessary cost of education should be reflected in charges for patient care.

We also believe that there should be joint exploration with the parties involved of whether and how the direct cost of graduate medical education can be reduced, without adversely affecting the quality of education or the quality of medical care.

The indirect teaching cost adjustment is intended to offset costs incurred by teaching hospitals when students order extra tests or procedures, place extra demands on other staff, and conduct more intensive treatment regimens as part of their education.

Presumably these costs are related not only to education, but to the characteristics of the patient population. Thus, a major argument for the indirect adjustment has been the higher costs associated with the sicker patients that teaching hospitals treat.

We believe that the prospective payment mechanism should be refined to more accurately reflect the differences in case load and specifically the degrees of illness within DRG diagnostic groups.

As the payment mechanism begins to reflect patient care costs more accurately, the indirect adjustment may become unnecessary.

We would encourage continued study of severity of illness indicators and other means of rendering the system more sensitive to the individual institution's actual clinical load.

The incentives of prospective payment, in our view, should be retained as that system evolves.

We understand that the indirect adjustment is used by many teaching hospitals to offset the cost of indigent care. We believe that indigent care costs should be addressed explicitly and we do not see them as an appropriate function of the indirect adjustment.

We do emphasize that withdrawing the indirect adjustment without simultaneously addressing the financing of care to the poor could have a very adverse effect upon those hospitals which have a high percentage of patients unable to pay.

In summary, our position is that the passthrough for direct medical education costs should be continued, at least until methods are available to price more accurately the patient care services that such programs provide.

Second, the indirect adjustment should be maintained as an interim measure pending the development of means of dealing more precisely with differences in the clinical characteristics of hospitals' case loads.

Third, any reliance on the indirect adjustment as a means of financing care for the poor should be relieved by strengthening programs to pay explicitly for care for the poor.

And fourth, it would be appropriate for Government to work with teaching hospitals, the medical profession, and others to explore ways of reducing the costs of graduate medical education without eroding its quality.

We appreciate this opportunity to present our views.

[Mr. Morris' prepared statement follows:]

TESTIMONY
OF
BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and members of the Committee, I am Lawrence C. Morris, Senior Vice President of the Blue Cross and Blue Shield Association. The Association is the national coordinating agency for the nation's Blue Cross and Blue Shield Plans.

We appreciate this opportunity to present our views concerning payment for graduate medical education under Medicare. We understand that the Committee will be reviewing the Administration's proposal to reduce Medicare expenditures for graduate medical education which would involve freezing payments for direct educational costs and cutting in half the adjustment for hospitals' indirect teaching costs. These proposals, the Administration estimates, promise savings of \$845 million in fiscal year 1986.

The Blue Cross and Blue Shield Association shares the Administration's concern for Medicare costs and the need to reduce the federal deficit. However, in our opinion, a freeze on the direct costs of graduate medical education and a halving of the indirect cost adjustment represent only a short term response and do not address the underlying issues. The Department of Health and Human Services has undertaken a major study of graduate medical education costs. We look forward to the findings of that study and would urge the Committee to consider them in any final action.

Teaching hospitals, through their graduate medical education programs, provide Blue Cross and Blue Shield Plan subscribers with a great deal of patient care, including specialized tertiary services. We believe that we have an obligation to pay for these services and their attendant costs when our subscribers use teaching hospitals. In order to recognize these costs, we negotiate with individual health care institutions.

The Blue Cross and Blue Shield Association believes that Medicare should continue to pass through the reasonable direct costs of graduate medical education, at least until

better information provides for a more accurate assessment of the costs of patient care received through the graduate medical education program. We also believe that there should be an exploration of whether and how the direct costs of graduate education can be reduced without adversely affecting the quality of education or the quality of medical care.

We believe that the DRG payment mechanism should be refined to accurately reflect severity of illness differences. As the payment mechanism began to reflect patient care costs more accurately, the indirect adjustment might become unnecessary. We realize that the indirect adjustment is used by many teaching hospitals to offset the cost of care provided to indigent patients. Any sudden elimination of the adjustment could, therefore, adversely affect access to care by the poor. However, financing care for the poor and financing education costs are two separate issues. Each issue requires explicit attention. Therefore, we encourage a more specific addressing of the financing of care provided to the poor, and maintenance of the indirect adjustment until this problem has been resolved.

Payment for Direct Costs of Graduate Medical Education

Medicare's past commitment to graduate medical education has had a positive effect on the quality and stability of our medical education system. The pass-through method of payment has provided a predictable source of funds and has enabled medical educators to develop and maintain strong training programs. It has also allowed prospective students to know that the programs they undertake will retain their quality. This predictability of funding is important, and argues for continuation as an interim measure of the pass-through method of payment.

Ideally, Medicare should finance an appropriate share of the costs of education in the course of paying for the necessary care of beneficiaries. However, to achieve this goal, Medicare would have to develop data and methods to isolate and separately pay for those medical education costs that are truly related to the provision of necessary patient care. In determining the methods to pay for these necessary costs, Medicare should take into account the amount it would otherwise pay under Part B if the services were provided by physicians in non-teaching hospitals.

For so long as the direct payment of teaching costs is continued, it may be possible to reduce the cost of education without adversely affecting its quality or the quality of medical care. One approach might be for HCFA to consider establishing more stringent criteria for Medicare-approved medical education programs. For example, it has been suggested that each teaching hospital be required to have an affiliation agreement with a United States medical school that attests to the quality of the hospital's program. The effect would be to require that hospitals justify maintaining a GME program on the basis of the quality of education provided, and on the ability to attract qualified house staff. This approach to reducing the costs of medical education could be explored jointly by government, teaching hospitals, professional organizations and the medical schools.

Indirect Teaching Cost Adjustment

The indirect teaching cost adjustment is intended to offset costs incurred by teaching hospitals when students order extra tests and procedures, place extra demands on other staff and conduct more intensive treatment regimens as part of their education. Presumably, these costs are related not only to education, but to the characteristics of

the patient population. Thus, a major argument for the teaching adjustment has been the higher costs associated with the sicker patients teaching hospitals treat.

The accuracy of the adjustment factor, based upon the relationship between operating costs per discharge and residents per bed, has always been debated. We share the Administration's skepticism regarding the accuracy of the adjustment. Doubling the adjustment may, in fact, have only magnified its inaccuracy. However, we would be equally concerned with arbitrarily reducing the total simply by cutting it in half.

The goal, obviously, is to contain indirect costs to the necessary level, and then to fund that level. The most promising alternatives to the use of an adjustment factor lie in measures to refine DRG prices. The more accurately DRG prices reflect the true costs of patient mix the less need there will be for adjustment factors for indirect costs of any magnitude.

Thus, we encourage continued study of severity of illness indicators and other means of rendering the payment system more sensitive to an individual institution's actual clinical load, retaining the incentives of prospective payment. There are few solid data on how the severity of case loads in teaching institutions compares with that of non-teaching institutions. In the absence of better severity indices some Blue Cross Plans have recognized severity through broader use of outliers. Medicare should consider a similar approach.

We understand that the indirect adjustment is used by many teaching hospitals to offset indigent care costs. We believe indigent care costs should be addressed explicitly. We do not see them as an appropriate function of the indirect adjustment. We do emphasize that withdrawing the indirect adjustment without simultaneously addressing the financing

of care to the poor could have a very adverse effect upon those hospitals which have a high percentage of patients unable to pay.

In conclusion, the Blue Cross and Blue Shield Association recommends that Medicare's commitment to medical education not be abandoned. We suggest that measures to limit payment for indirect costs be considered cautiously, with recognition that medical education is a long-term process, requiring long-term planning and resource commitment both by teaching institutions and by individuals. However, we do believe that it is appropriate to explore ways in which education costs can be reduced responsibly.

In summary, our position is that:

- o The pass-through for direct medical education costs should be continued, at least until methods are available to price more accurately the patient care services such programs provide.
- o The indirect adjustment should be maintained, as an interim measure, pending the development of means of dealing more precisely with differences in the clinical characteristics of hospitals' case loads.
- o Any reliance upon the indirect adjustment as a means of financing care for the poor should be relieved by strengthening programs to pay explicitly for such care.
- o It would be appropriate for government to work with teaching hospitals, the medical profession and others to explore ways of reducing the costs of graduate medical education without eroding its quality.

Thank you for this opportunity to present our views.

Mr. WAXMAN. Thank you very much.
Mr. Goldbeck.

STATEMENT OF WILLIS B. GOLDBECK

Mr. GOLDBECK. Thank you. I am Willis Goldbeck, president of the Washington Business Group on Health.

I think the single most important message that I would want to leave you with is that the business community must be involved in this issue. That is a dramatic change from the passive role it had taken historically in the development of the very programs we are now talking about changing.

It is an important change, and one which we cannot do without. Business will have to pay its fair share of this Nation's medical education bill by whatever methodology you and others decide that is to be doled out. There is no escaping that obligation.

Today few of the conditions upon which our medical education system were constructed to work with continue to exist. Certainly infectious diseases are no longer the major determinants of health status. Clearly there is no longer the shortage of physicians in the vast majority of specialties.

Distribution or access are certainly still issues, but there is no evidence that they will be solved by raw numbers of any particular specialty.

I must note it is somewhat ironic that the National Health Service Corps, which is in the process of being eliminated, has been the most effective method we have ever come up with for dealing with distributional questions. Some 70 percent of its placements have remained in the counties of their service, after their service obligation was completed. Yet that is now the program we are going to eliminate.

These are complex issues that have come to the business community, largely through the accountability systems that business, labor, and Government have extracted from the medical industry in the past few years. The new accountability really is at the heart of the more competitive purchasing of medical care, and that can be a double-edged sword from the perspective of graduate medical education. Today, employees can see the price on an institutional, procedure or provider specific basis.

When they do that they can determine that it makes a heck of a lot more sense to buy care from provider A than provider B. In some instances this will be devastating to teaching hospitals. But it will not only be—and I think this is terribly important—this will not only be because they are teaching hospitals. Business can look at Boston and at New Haven and take comparable quality teaching hospitals and discover the ones in New Haven cost roughly half the price of the ones in Boston. And that can't be simply because of geography.

We see comparable variations on a procedural basis. We see even more dramatic variations within individual teaching hospitals when you look at physician-specific practice patterns, testing patterns, infection rates, et al. Therefore, it is becoming increasingly clear to our purchaser constituency and I trust to the rest of those

who are involved in this issue, that it is very hard to talk generally about teaching hospitals on medical education.

When we see that teaching hospitals have this degree of variance, it becomes more and more significant to think in terms of purchasing care by procedure rather than only by institution. So if you were to look at the District of Columbia, for instance, and look at all of the teaching hospitals that serve this area, and if you were a buyer of medical care here, you would not put all of your purchases in any one of those institutions. You would find certain of those institutions more appropriate, both economically and qualitatively, on a procedural basis, not an institutional basis.

Teaching hospitals, I think you would find the business community feeling, have no right to life. One of the things that we are hearing today, and in other medical industry pronouncements, is teaching hospitals, of course, should be supported because they are ipso facto good. The Government stimulated their growth X number of years ago, thus they have a license. Thus, nonsense.

There is no contract in perpetuity. There is also not necessarily any purpose in perpetuity. And I must say that it is refreshing to hear several of the past two panelists—which were really excellent—so frankly acknowledging how terribly poor they as leaders in their profession feel some of these teaching institutions are. I think we should publish the names of those institutions. I don't know why the employees of any company, I don't know why the covered population of Blue Cross, or the commercial carriers, or the beneficiaries of government programs, should ever be directed to a teaching hospital that the best people in the profession say is lousy.

If nothing else can come out of this hearing, perhaps public disclosure of teaching hospital quality can result. Although I dare say you could bring another panel in that would object very much to having the names made public.

Medical education needs to be explicitly financed. When business knows what it is being asked to pay for, it is quite willing, by and large, to pay unless the cost is just totally out of hand. We do not find any of our companies that we have dealt with directly that have said they don't believe they should pay for medical education or research. But they are often told to pay for the true costs of medical education: they ask what that is, and nobody in the profession seems to have an answer. Or they all have the same answer: "whatever we want to charge you. It's what we say our cost is, of course."

Neither of those answers are responsive to the question.

We are going to have to determine what it is we want to pay for. And I would hope that we really resist the temptation to simply divvy up an existing pie among competing folks. Instead let's ask the question of what is it that we want to pay for, and then set the payment that is germane to obtaining that objective. We will have a lot better medical education results in the long run.

Certainly some medical schools will close. Pressures from competition, from Government, regardless of the immediate administration's proposal, will produce such a result. We would urge that there not be simply attainment of mediocrity by constantly ratcheting down amounts of money that are distributed.

It is time to face up to the fact that we need to purchase excellence where it exists or where we would like to stimulate it. Where we find mediocrity and worse, say no more. If those institutions can survive without support, that is one issue; but at least they should not be tax supported.

Certainly I think it is important, as you have heard through this hearing, that a lot of the pressure on that linkage between access and education does not come specifically from the private sector or irresponsible businesses or whatever; it comes from other hospitals that are electing not to provide care.

I was struck by the discourse earlier in the day on the long hours worked by the poor residents, I would suggest this is not to be viewed societally as a badge of courage when in fact it is a guarantee of exhaustion, impaired decisions, as poor patient communication. Cheap, overmarked labor does not equal good care.

I was struck by your comments, Mr. Bilirakis. In some cases, mediocre care can be better than no care. At the moment, we seem to accept that this is a necessary condition, yet I am not sure that we should. I think it may demean all of us to do so.

On the foreign medical graduate issue, business obviously does not have a uniform, analytical approach. One thing is very clear when you look at the numbers. This is not an alien invasion. The vast majority are the sons and daughters of those businessmen who were rejected by U.S. medical schools that want to keep the lid on the number of people getting into the profession.

U.S. graduates, 58 percent of them, get their first choice of medical school and residency programs. Eighty-eight percent are accepted within their first four choices. This is hardly a deprived population in that regard. So we need to separate the alien and the U.S. issue. We need to decide are we going to pay for bad quality foreign medical education.

The answer to that should be no regardless of the school's location. We need to establish a standard. Those FMG's who fall above it are just as good, by definition of the standard as those domestically educated. If we choose to include foreign citizens, that is another issue entirely, but the standard should not change.

One of the things that must come out is a consideration of competing societal values. It would be relatively easy to simply decide to allow only so many people to be doctors in America. That resolves certain of the economic constraints and pressures. It also totally violates a basic American ethic having to do with employment. So some of these issues will not be resolved by a health-only perspective.

I think you would find the business community, even in the face of medical care cost pressures, very reluctant to come before you and advocate a policy that provides a governmentally-imposed restraint on the ability to seek employment in any profession, or any nonprofession, for that matter.

I don't think you will find much sympathy in the business community for the constant whining of the profession about the terrible debt loads these young folks accumulate in school. It is no more debt than the average small business person incurs running a mom and pop store, a gas station, or even, heaven help us, a small consulting firm like ours.

I would love to be able to start our magazine and know that we are going to have everybody in our organization have a \$100,000 income in a couple of years. It doesn't happen. The young physician's plight is not disproportional to the rest of our society in a great many ways and will not engender tremendous sympathy.

I think the Federal role in medical education becomes increasingly clear. Support excellence and do no more. Design the programs to meet need where it is clear, with a longer term view than we have historically used, and recognize that there is a place for reform within medical education.

There is an expressed desire for supporting the status quo in much of the commentary we have heard today. That would be a terrible mistake because there is a lot to be achieved through improvements in medical education itself. A few of those items would include dramatic increase in work on outcomes of practice patterns. We must begin to have physicians who are trained based upon a set of standards of excellence emanating from an analysis of what produces high quality health outcomes and less variations in physicians' practice.

Also, there needs to be an increased emphasis in medical schools on the continuum of prevention that is beyond the scope of just primary care. Further, even some of the best, as we now perceive them, medical schools in America still only require 3 to 6 hours in the entire medical school curriculum for all of health economics, prevention, behavioral sciences, communication and social sciences. This clearly is less than adequate to meet needs of the society in which they are going to practice medical care.

We must recognize the fact that we are facing the fastest growth in the under-65 population we have had in years, combined with the fastest-growing cohort in America being those over 80. We are in a squeeze. Medical education must face up to that reality.

We hear a lot about the fact that we have too many doctors. We also have a number of geographic areas and medical specialties where we have just a fraction of those needed. Gerontology is one.

Somebody spoke this morning, I apologize for not remembering the name, and noted that we should sustain much of our current practice of graduate medical education, because in the future we are going to have all these old people that are going to need to be spending their last years in the hospital.

Please do not follow this advice. The last place in the world most old people need to spend their last years is in the hospital. Further, most physicians today are not coming out of medical school with one iota of training about gerontology, so the fit is not there.

The same gap between supply and demand could be said for toxicology, in which case industry is a potential large employer of new physicians.

One of the factors that I have not heard today, that will help determine whether or not you set limits on medical education, is the role of the nonphysician medical provider: how many of them, by what educational system, with what reimbursement process.

We look at the 1981 study by OTA which was reviewed and updated yesterday, and it substantiates a great many areas where the nonphysician provider is indeed superior, much less comparable, to

the physician in providing patient care at a significantly reduced rate of cost.

My last point is to say that while we have talked blithely in the United States about physician excess and having more medical care than we can possibly need, there remains the rest of the world, which has none of the above. It seems to me one test of the commitment of our Nation, and certainly of those who would be called healers, is whether or not medical education in the United States serves only our immediate needs or if, indeed, it helps to improve the health status of the globe.

Thank you very much.

[The prepared statement of Mr. Goldbeck follows:]



Washington Business Group on Health

WILLIS B. GOLDBECK

and

RICK LEE

I am privileged to appear before you today as President of the Washington Business Group on Health. As many of you know, we are the only national organization comprised of major employers who recognized, eleven long years ago, the necessity of responsible participation in health policy and cost management deliberations. Although small in number, the impact of the purchasing decisions of these companies is of undeniable magnitude: approximately 50,000,000 insured employees, retirees and dependents.

Your focus on graduate medical education today is of critical importance to payers and patients in our health care system.

The advent of business' concern with health care cost escalation has precipitated a greater urgency for accountability. As payers for more than \$100 billion annually in health care costs, business has been exacting more accountability from physicians, hospitals, other providers, insurers, employees, and government.

The demand for cost-effective medical services and a reduction in hidden subsidies for capital accumulation, uncompensated care, and the cost of medical education has required a more explicit accounting for the vast array of socially redeemable services rendered by hospitals. These hidden subsidies are not necessarily wrong. They, in effect, were sanctioned as forms of taxation by payers who accepted the need for covering those services. As an unconcerned and uninvolved payer, business helped create a laissez-faire attitude in which accountability was lacking. Times have changed, however. The increased surveillance

exhibited by business has been accompanied by a taxpayers' revolt and this Administration's desire to restrain the federal government's financial participation and prominence in health care.

Public and private sources of funds are in greater need to meet the costs of hospital services, hitherto paid for through tax revenues and hidden subsidies. What is not apparent, however, is the degree to which taxpayers or third-party payers, as agents of patients, should retain their crucial roles in funding the next generation of educating and training medical personnel or funding research.

The era of accountability and more aggressive and prudent purchasing of health care will not be turned back. Hospital and diagnosis-specific price data now made available through state and community disclosure efforts, has uncovered the vulnerability of teaching hospitals in a price-competitive marketplace. Blue Cross' SelectCare in Maryland isolated the state's teaching hospitals from participation. Similar developments have occurred in Indiana and Cleveland. PPOs in San Diego, Miami, as well as price lists in Chicago, Kansas, and California have consistently exposed the charges of academic medical centers as excessive compared to their competitors. As consumers become emboldened by economic incentives like coinsurance, to evince more price-sensitivity in their selection of hospitals, the high cost institutions will lose market share. Hospitals that spread the cost of graduate medical education among all patients will be perceived as less attractive. This outgrowth of prudent purchasing has obvious adverse

externalities. It requires the leadership of government and the contribution of all parties involved, including my constituency - business, to arrive at a solution that will preserve our teaching hospitals and their valuable role in this country's medical delivery system.

Graduate medical education now exceeds \$4 billion a year. The current patchwork of patient revenues, tuition, subsidies, research funds, grants, and other sources for this costly enterprise is unraveling, creating the need for a more cogent federal policy.

Critical Issues

There are a number of critical issues that must be acknowledged and addressed in order to resolve the current political dilemma:

1. Can federal funds to ameliorate physician maldistribution by race, specialty, and geographic location be better employed?
2. If so, what are some of the criteria that should accompany the dollars distributed to medical schools and teaching hospitals?
3. Who should pay for graduate medical education and how should it be paid for?

4. Recognizing that the indirect subsidy was created in part as a proxy for patient severity, wouldn't reduction of the subsidy without substituting a more precise case-mix measurement be irrational?
5. If the impending physician surplus signifies an opportunity for diminishing the federal role, what is the most appropriate approach for scaling back the medical education system's capacity? Does such a shrinkage fully account for the more modest practice styles typical of proliferating HMO physicians?
6. To what degree can conservative practice styles, relatively free of unnecessary treatment and induced demand, become the standard against which the next generation of physicians is trained?

In searching for a reasonable and prudent graduate medical education policy, we must not lose sight of the differences in mission, practice style, and operations that characterize the institutions that carry the greatest burden. The Mayo Clinic, deemed a model for quality, prestige, and accountability, has achieved its heralded stature despite adherence to a conservative practice style that makes per capita costs in Olmsted County 20-40 percent less costly than those for a similar population in the environs of the University of Minnesota's medical complex.

Jack Wennberg, the noted Dartmouth physician and epidemiologist, has uncovered similar inconsistencies while examining the difference between Boston and New Haven. If there is a relationship between the level of resource investment and quality of care, research, and training associated with a teaching hospital; it is not apparent to physicians who have graduated from Yale and Harvard medical schools. Though the New Haven health care market in terms of volume and price is half as costly as Boston (\$215 per capita in 1978 vs \$448), clinicians trained in the two schools of medicine are oblivious to these marked differences. Two highly respected medical schools are thus graduating physicians with different practice styles that ultimately are paid for by their community's residents.

The true test of accountability for the 125 academic medical centers is best borne out by the Boston-New Haven example; if the direct and indirect subsidies have resulted in generous profit margins for some teaching institutions, then this government must arrive at a more precise method of allocation. More importantly, the method of paying for graduate medical education needs to incorporate incentives that will prod those institutions, in this time of fiscal austerity, towards increased efficiency. They must accept the mission of training a generation of doctors that are not ignorant of the costs of tests, invasive treatment, and unnecessary utilization.

In focusing on this complex issue, I urge the members of this committee to consider the following:

- Funding sources must be stable. Institutions that have made a long term commitment to graduate medical education cannot attend to their mission plagued by the uncertainty of funding.
- As a nation, we must distribute the burden equitably. Some question why Medicare should even pay for teaching. If the payroll tax which takes money from workers, not elderly beneficiaries, is the most progressive means of accumulating funds for graduate medical education, etc., so be it. We must recognize the degree to which some states are educating and training doctors for other states (without state-funded medical schools) and recognize these implications if this financing problem is going to be thrust into the states' hands.
- Though accounting for only 5.6 percent of the acute care beds in 1982, teaching hospitals across the country provided 47.2 percent of the free care. Cutbacks in graduate medical education funds will jeopardize charity care provided to the indigent as well as to the employed, but uninsured patient. Neonatal intensive care units, burn centers and trauma centers will be financially compromised if our public policies do not consider the uncompensated issue as a component of graduate medical education financing.

- Teaching programs differ dramatically in mission, size, emphasis, efficiency, and goals. If this nation intends to continue its goal of reducing access problems for underserved areas, greater accountability of these teaching programs, with respect to the ultimate choice of specialty and geographic location of practice made by their graduating physicians, will have to be required.

- As we are learning in the health planning arena, shutting down inefficient hospitals is extremely difficult. The imminent physician glut suggests that, as a nation, we must also consider shutting down teaching programs. Since the purse strings are controlled in Washington, it may make sense for a reappraisal of the existing medical schools. Since feeding the doctor surplus is not in the best interests of the country, eliminations of entire programs may be called for. On the other hand, five and ten percent reductions in class sizes will not result in sufficient savings to remedy the problem.

- Foreign medical graduates (FMGs) are integral to the issue of graduate medical education. Currently residency slots are in great demand. Institutions in inner cities with a disproportionate share of the indigent also tend to be residency locations for foreign medical graduates. In assessing the need for physicians and the available residency slots, analysis of FMG penetration, Veteran Administration programs and other contributing factors must occur.

The issue of graduate medical education is a complex one. Interwoven funding streams from many different sources has confused analysis and policy proposals. Nevertheless, our system for all its faults and shortcomings, produces the finest medical personnel in the world. We must now make that system more accountable to heightened budgetary scrutiny without compromising quality. It is a difficult but critical goal to pursue.

Mr. WAXMAN. Thank you, Dr. Goldbeck.
Dr. Anderson.

STATEMENT OF GERARD ANDERSON, Ph.D.

Dr. ANDERSON. I am Gerard Anderson, associate director of John Hopkins Center for Hospital Finance and Management, also associate professor of Economics and Health Policy at Johns Hopkins.

I am pleased to be here this afternoon to present a proposal which would merge health manpower training and hospital financing. The proposal is based upon the premise that the specialty and geographic distribution of physicians, as well as the training of allied health professions, is a national concern and that the Federal Government should continue to play a major role in health professions education.

It also assumes the decision to add or eliminate a specific training program should remain the responsibility of the individual institution, subject to approval of private accreditation bodies.

Finally, it recognizes that Federal resources for financing graduate medical education and allied health professions training are limited and that funding must come from existing sources.

The primary source of funding for this proposal is the approximate \$1 billion in Medicare funds currently allocated for direct education costs. These resources for graduate medical education training were created when Congress separated hospital operating costs and educational costs in the prospective payment legislation.

Congress also created a category which you have heard a lot about today called indirect medical education costs. These costs are not incorporated into this proposal at the present time because the adjustment for indirect medical education includes many factors in addition to education which cannot be accurately separated with available data.

As more information on the portion of these costs which are directly related to education become available, indirect costs could also be incorporated in this proposal. Funds from title VII could also be incorporated into this proposal at the present time if you so desire.

The basic proposal begins by allocating the \$1 billion in Medicare funds for direct medical education. Currently the Medicare Program provides partial support for 66,000 residents in approved residency programs. Dividing the \$1 billion in direct funding by the number of residents indicates that Medicare provides an average of \$15,000 in support for each resident. This includes Medicare's share of all payments for resident salaries and fringe benefits, teaching physician salaries and fringe benefits, overhead and administrative costs.

In this proposal, the payment would follow the resident wherever he or she was training and would go directly to the institution providing the training. The institution would use the resources to pay the salaries and fringe benefits of the resident as well as provide the administrative support and training.

The result of this proposal is that individual differences among institutions for overhead and supervisory costs would not be recognized. My analysis shows that individual variations among institu-

tions in overhead and supervisory costs vary substantially from institution to institution.

Any institution, including academic health centers, community hospitals, HMO's, or rural health clinics, with an improved residency program would be eligible to receive this payment. This would encourage the expansion of training into sites outside of the hospital. Institutions would be free to expand or contract current programs, subject to the approval of their specialty boards.

Similar types of payments could be developed to support allied health profession training as well.

To create incentives for training more physicians in areas of specialty shortage, support level could then vary by specialty. Appropriate funding levels would be determined by Congress in conjunction with the Department of Health and Human Services. Prices would be based upon a national health manpower policy agenda determined by the supply and need of physicians in each specialty area.

This policy could begin at the current level of equal payments for all specialties, gradually increasing payments for medical training in designated specialty shortage areas such as preventive medicine, and reducing payments in those programs where a surplus is known to exist, such as neurosurgery.

The proposal is geared toward changing the behavior of the hospital by creating financial incentives to offer more positions in specialties of undersupply. Because many residency programs select their residents as much as 18 months in advance of their starting date, this policy should be phased in gradually, perhaps over a 3- to 4-year period.

For example, in the first year, all specialties might be funded at the same level of \$15,000. Funding would then be distributed differentially in year two when the universe of training programs was divided into one of three groups: those of undersupply, those of balanced supply and those of oversupply. Those terms were taken from the GMENAC report.

Then I present in the text a table. What the table shows is the funding for residencies of oversupply would go from \$15,000 down to \$6,000. Residencies in undersupply over a 4-year period would go from \$15,000 to \$24,000 in gradual steps, and those in balanced supply would remain at about \$15,000.

Eventually the numbers of categories might be expanded to further segment the training programs, and thus more precisely provide incentives for training positions according to a public manpower policy.

Payment levels could then be allowed to increase for inflation. The Federal precedent of willingness to vary price based upon need is found in a number of places. It is found in the armed services, where compensation is directly related to specialty. Based upon a manpower agenda developed the Armed Forces, physicians receive end-of-year bonuses which vary by specialty. This system is updated periodically to reflect changes in manpower needs.

In addition, several years ago when Congress wanted to increase the number of psychiatrists, it paid hospitals a premium for expanding psychiatry residencies and the hospitals responded by substantially increasing the number of positions.

As you heard this morning, hospitals expanded primary care residency programs as a result of title VII.

Although this program is generally designed to influence the specialty distribution of physicians, several other modifications could be easily introduced to achieve other public policy concerns. It is frequently acknowledged there is a geographic maldistribution. This proposal could be modified to encourage residencies in rural setting by increasing the payment levels in these areas. Payment levels could also be increased in residency programs such as primary case which are not frequently found in the innercity.

In this way the mix of physicians trained in these areas might be altered to accommodate the medical needs of the community.

The proposal could also be modified to adjust payment levels based upon on the number of Medicare beneficiaries treated in the facility. Payment levels could be adjusted upwards for facilities which treat a higher than average share of Medicare beneficiaries, and reduced for facilities which treat a lower than average share.

The proposal could be used to control Federal expenditures. One possibility which we heard a lot about today is to fund only the first 3 years of the postgraduate training. This would save approximately \$160 million in Medicare part A expenditures, although the total effect of savings is rather unclear because probably part B expenditures would increase.

Another option, again which we have heard a lot about today for reducing expenditures, would be to limit funding to graduates of U.S. medical schools. Such a move would eliminate the funding to about 13,000 residents, and save an additional \$200 million. Other public policy or budgetary savings objectives could be addressed by adjusting the financing system.

I believe this proposal has several advantages over other options which have been presented today and in other places.

The financing system would begin to reflect public policy concerns about physician supply and geographic and specialty distribution. Something which it does not do currently.

The system allows the individual institution, in conjunction with the specialty boards, a choice of which specialties to offer, and how many residents to train in each program. The Federal Government is not interfering with the institution's choice of training programs.

The system is basically site neutral, favoring neither large nor small programs, public or private institutions, hospitals, HMO's, et cetera.

The system is administratively simple and would place no additional reporting burden on hospitals.

The system allows the Federal Government to control its total financial commitment to educational programs.

It can be easily modified if manpower priorities change.

And finally, it is flexible and allows you to incorporate additional policy objectives as they might arise.

I would be glad to answer any questions.

Mr. WAXMAN. Thank you very much, Dr. Anderson.

Mr. WAXMAN. Mr. Morris, let me start with you. You indicate you believe you have an obligation to pay for graduate medical education costs when your subscribers use teaching hospitals. We have two followup questions to that: Do you try to avoid using

teaching hospitals because of their higher costs in providing care to subscribers?

Mr. MORRIS. Typically we haven't. There is emerging a phenomenon which has been discussed several times today. And that is the driving of a system by price considerations rather than by cost considerations or charge considerations.

I am not sure where that ultimately is going to lead. At this point in its development, most of the Blue Cross and Blue Shield preferred provider arrangements do in fact include teaching hospitals.

As we talk with the plans, we get intimations that the pressures are getting more and more severe on price. But the fact remains that in Minneapolis-St. Paul, for example, which is probably the most competitive market in the country for a number of reasons, all of the teaching hospitals are on the preferred provider operation. They have met the price.

I think it clearly is going to be the case that price will, as it pushes down, begin to segment those markets. That would seem to me to make it more important that we get better means of measuring case mix, severity of illness, so that we can in fact recognize what service is being provided. The bottom line of the commitment is to pay for the services that have been provided. That does imply an understanding, in a greater depth than we really know how to deal with at this point, of how to define the product.

Mr. WAXMAN. When you pay for patient care that involves graduate medical education component to it, how do you figure the reimbursement? Is it a similar one to what the Medicare system does, the concept of direct or indirect cost?

Mr. MORRIS. No, it isn't the same. In this system nothing is done any one way. There are a variety of ways in which it is addressed. The basic cells are costs and charges, prospective and retrospective, negotiated budget reviews, State regulation. They all apply differently in different places.

Charges have the advantage that they incorporate the direct and indirect cost as well as capital costs, for example, but they are subject to negotiation, the test of reasonableness.

Referring back to the last question, increasingly the test is how do they compare to other charges in the community, to the standard of the community. The fundamental denominator, except in State-regulated States, is a negotiation of reasonableness, but it may be either prospective or retrospective, cost based or charge based.

Mr. WAXMAN. Mr. Goldbeck, concerns have been expressed that employers interested in restraining their costs for health benefits will avoid the use of teaching hospitals, which will also mean they will avoid contributing to the training of the new physicians.

Do you think these concerns are valid?

Mr. GOLDBECK. Yes, I think there is some reason to be concerned, particularly in communities where teaching hospitals have dramatically higher prices and there is no apparent diminution of the quality of care for the corporation's own covered employees and families if they go elsewhere.

You heard a case described earlier where one institution was the only place available to get certain categories of care. In a lot of

communities that isn't the case. They have a choice among a half a dozen or more institutions.

As you know, with the massive duplication of facilities and services, if one is doing as high quality as can be assessed is significantly less expensive, then you will find some employers purchasing there. There is no question about that. In some areas, this will hurt teaching hospitals.

That is different than whether or not employers would be willing to pay for medical education if they were presented with a methodology for doing so.

Mr. WAXMAN. A methodology by which you would be asked to pay as a component in the reimbursement for care for those patients that are part of your program in reimbursing those who give them those services.

Mr. GOLDBECK. We have advocated that all payers, and that includes our members and any self-insured employers must share in the costs. So if there is a State distribution method, or there is a Federal surcharge to nonteaching institutions for the price of teaching care, or any number of other methods, that is conceptually perfectly acceptable. Somebody might stick a number or percent on it we quibble about, but conceptually there is absolutely no problem with that, nor should there be.

I cannot guarantee some employer in a given community won't behave in a way that at least our policy value or structure would suggest is wrong. From our standpoint, sharing of medical education costs is an essential element of national health policy.

Mr. WAXMAN. There is a great move among business sharers to try to hold down costs, and that often leads to HMO's and PPO's and other forms where there is a lot of competition. There doesn't seem to be a lot of competition for some of the patients that these teaching hospitals seem to take care of.

How would you be contributing to that? How would you envision business contributing to that? And what economic sense would it make for your principals to be putting in money for care of their clients or employees when they can go out and get some care that is quite good, if not better, at a cheaper price? Don't they have an obligation to follow the economics?

Mr. GOLDBECK. They have an obligation to follow economics, but only to a degree. What many do is going to depend on how they measure cost-effectiveness and over what period of time, how they view their role in the community. It would be quite possible for a great many large employers to simply sidestep the entire medical care system and have their own facility. That has been possible for many, many years, yet only one or two examples exist in the whole United States. Others have chosen not to do so. Because they felt it would be an inappropriate diminution of the community resource that otherwise needs their economic participation.

We see the same thing in a number of examples in education, in transportation systems where companies can provide services to "their people" in a rather protectionist way far less expensively, yet they choose not to do so.

Many of the people who run these companies come out of these communities and they serve on the boards of hospitals. A great many of the hospitals, I might add, including some of the bad ones

as well as some of the good ones, carry the name of these companies as the contributor-financier philanthropist. They have felt that sense of obligation for decades and I don't see a major diminution of that. I see a great deal of confusion to that because it is becoming more apparent what you buy, I would say, that this is picking up on something that Larry said—not by way of criticizing what you said, but it raises the example. There is virtually no indication of reasonableness anywhere in the system. You can't go by what the hospital said was reasonable 5 years ago or 3 years ago. There are virtually no acceptable norms because the norms contain all the garbage that we are in the process of trying to correct.

Look at the standards we attempted to set up: Four beds per thousand. Now we know major communities are served extraordinarily well at two, so why should we continue to set four as a marvelous standard or norm?

COMMUNITY STANDARDS

I don't know that we want community standards. Do we want to have everybody trying to achieve the Boston community standard or the New Haven community standard?

Mr. WAXMAN. Let me suggest to you, I thought your statement was very challenging. I am going to have to think through what you have to say, because it seemed to me it made a lot of points. It seemed to be at variance with a lot of what we were hearing all day, where people were talking about a proposal that we are facing under the Reagan administration. How do we deal in response to that.

Unfortunately, we have to deal in the Congress of the United States under budgetary pressures; not just because we want to hold our money, but we are making health care policy by virtue of the budget driving it. And that doesn't always lead to the best policy.

It seems to me you are outlining a lot of good points for us to look at as we decide what health policy ought to be.

What troubled me about your statement is that a lot of what you said we ought to do is probably going to cost more money and your response probably would be, "Maybe it will, maybe it won't in the long term, but a lot of these things make more sense if they are more cost-effective."

I find that challenging and frustrating because no one else is suggesting we do that. It is very hard to do that under the system by which we operate. So, if we try to narrow down our focus and we are faced with reimbursement under Medicare for institutions that not only provide the care, but have all these other special parts to them, such as teaching doctors and their specialties, providing intensive care, faced with a certain patient population that is usually sicker and more indigent among them, we try to do that and we try to figure out this extra part of the reimbursement on Medicare. Do you think we ought to just come up with a flat figure, as the administration is now suggesting we cut in half, or do you think we ought to use this opportunity to formulate some way to try and address the specialty maldistribution questions, as well as give some other incentives for some of these broader policies?

Mr. GOLDBECK. The latter, unequivocally. I mean the greatness of what the opportunity is which resides in Congress is the opportunity to change policy. You don't have to be an accountant. I have not seen one iota of evidence that either 5.8 percent made sense once before or didn't make sense, or how it should make sense again, and heaven only knows what was in between. We know even less about what's going to make sense for the crop of people as they come through our pipeline 3 to 7 years hence.

So, you know, faced with the necessity to do some arbitrary number setting, you are not going to get much advice, I'm afraid, that's of good counsel as to exactly what an arbitrary number ought to be. And probably the final determination will be in the reconciliation meeting at 2 in the morning. But along the way to those numbers, what you suggest is absolutely right. Some of the messages were reasonably clear today. Yes, we should support primary care. If you have to make choices and make cuts, that should not be what is cut. That should be what is increased.

Mr. WAXMAN. That's the economics, how the teaching hospitals see their interest, how the students see their interest, and it is always tough to go against the economics. You have got to change the incentives, because the incentives are against doing that.

Mr. GOLDBECK. That is correct. So to some degree, and I am not in any way trying to make your task easier—

Mr. WAXMAN. I have already come to that conclusion.

Mr. GOLDBECK. To some degree, the challenge is one of whether or not we wish this policy decision to be driven by the interest of the students or the patients. We already have entirely too many patients without primary care.

Mr. WAXMAN. I think we do have a real opportunity in front of us. It gives us an opportunity to explore these health policy considerations.

I think you do see business as an important component in thinking through what direction we should take in participating in the solution, because one of the fears that came up during the course of this very long day was that we are going to find more and more it is going to be Government's job, as business and private insurers opt out of the whole system of financing graduate medical education. We have got to figure out how to keep you involved, because we don't want to do it alone.

Mr. GOLDBECK. I think there are even some signs already. You know, we were the first organization in the country to oppose the arbitrary Medicare freeze.

Mr. WAXMAN. I am very impressed with your testimony because I put it in the context of I know what you are proposing in the many hearings we have had, and you personally have enormous amount of credibility with me in terms of having thought through these questions. And I appreciate it.

Dr. Anderson, I am going to look forward to looking through your proposal. We have heard some generalized ideas. You have given us specific ones. I think that is going to be very helpful to us as we try to think through what the options are and what would be a responsible approach for us to take.

So I express my appreciation to you.

Mr. Bilirakis.

Mr. BILIRAKIS. I won't ask any questions, Mr. Chairman. I don't dare.

I would like to thank the members of this panel, particularly, and all the members of the audience who stayed on better than 7 hours long this hearing, Mr. Chairman. I don't know where you get the stamina, either. But I have learned a lot, and I would like to thank all of these gentlemen and Dr. Anderson for your proposal, and Mr. Goldbeck, God bless you for your wisdom. I have asked particularly for a copy of your testimony, and shame on us if we get into a subject with any more meetings and ignore your comments and advice. I feel very strongly about that.

Thank you very much, gentlemen.

Mr. WAXMAN. I thank everybody, the three of you particularly for this, I think, exceptionally good hearing. It has been, I think, a very fruitful one. I appreciate everybody's participation.

We stand adjourned.

[Whereupon, at 4:55 p.m., the subcommittee hearing was adjourned.]

[The following statements were submitted for the record:]



AMERICAN OSTEOPATHIC
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STATEMENT OF THE
AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION
BEFORE THE
HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
ON
MEDICAL EDUCATION FUNDING BY THE MEDICARE AND MEDICAID PROGRAM

APRIL 3, 1985

Introduction

It is a pleasure to present the osteopathic hospital perspective on issues pertaining to medical education - the most critical policy area facing our profession. The American Osteopathic Hospital Association, (AOHA) represents the nation's over 200 osteopathic hospitals and teaching institutions.

Osteopathic Hospital Profile

Osteopathic hospitals serve as the primary institutional care facilities for those individual consumers who choose to receive their care from over 22,000 practicing osteopathic physicians in the United States. Osteopathic hospitals have nearly 25,000 beds available and in 1983 treated about 845,000 inpatients and nearly 4 million outpatients. In this era of competition, osteopathic medicine represents the only recognized comprehensive alternative to traditional medical care.

Our institutions and medical profession emphasize wellness and preventive care resulting in a "patient oriented approach" to medical treatment. Osteopathic hospitals provide a health care choice to the American people based on a distinctive medical philosophy offering patients a personalized, wholistic, "hands on" approach. With many of our hospitals located in rural and semi-rural areas, and with nearly half of our institutions having less than 100 beds and 80% having less than 200 beds, the osteopathic hospital profile reflects a very special community orientation. The fact that nearly 90% of practicing osteopathic physicians deliver primary care with half practicing in

communities of less than 50,000 persons, is further evidence that our profession is on the cutting edge of community health care needs. With this backdrop, it is our pleasure to convey to the Subcommittee the trends we see developing in osteopathic teaching hospitals; a description of the osteopathic model; an explanation of the vital role medical education plays in our hospitals; and, the effects of current Medicare policy on the osteopathic teaching institution. We will also present our evolving thoughts on options under consideration in the federal policy arena.

The Osteopathic Teaching Hospital

The training of tomorrow's general practitioners and family physicians is a top priority for osteopathic hospitals. Federal policy regarding the treatment of medical education costs was the Association's major policy concern during the deliberations on Medicare prospective payment and continues to be today. The reason for this is evident when examining the role osteopathic hospitals play in training osteopathic physicians. Of the 200 osteopathic hospitals in the United States, 111 are teaching institutions. The overwhelming majority of our teaching

hospitals are community facilities and not academic health centers. In fact, all of our community hospitals with 200 - 299 beds are teaching institutions, while 70% with 100 - 199 beds have teaching programs. Only four of the fifteen osteopathic medical colleges currently operate teaching hospitals.

When considering policy regarding the financing of medical education under Medicare, AOHA believes that the needs of the smaller community hospital with a teaching emphasis should be reflected.

The Osteopathic Teaching Model

The osteopathic teaching hospital role in training general practitioners and specialists begins during the osteopathic medical student's undergraduate training. Our educational model stresses clinical exposure through externships and clinical clerkships. This type of hands on clinical education is an essential ingredient to train the osteopathic physician. As recent news reports have indicated, traditional medical education is being criticized for not emphasizing "hands on" exposure. Unfortunately, current federal policy is already having a negative impact on the further development of these needed clinical experiences. The Health Care Financing Administration has defined

such clinical training of students enrolled in medical education programs as a normal operating expenditure of hospitals. Thus, the funding of such undergraduate clinical clerkships must be supported directly from the prospective payment rates. With the census dropping in osteopathic hospitals nationwide, and pressures to curtail certain services growing, our institutions are finding it increasingly difficult to support these essential undergraduate medical programs.

The osteopathic hospital has traditionally had primary responsibility for the conduct of internships and residencies. Under the osteopathic graduate medical education model, all osteopathic physicians must engage in a one year rotating internship during which they receive clinical exposure in a multitude of medical areas. This builds the foundation for the general practitioner - the backbone of the osteopathic profession. Completion of the rotating internship allows an osteopathic physician to practice general medicine under all federal statutes and all state statutes with the exception of New Hampshire, where two years of postgraduate training is required for all physicians.

Residency training, especially in the primary care specialties, is playing an increasingly important role in our teaching hospitals. While our general practice model consists of a one-year rotating

internship followed by a one year residency, other specialties require from two to six years additional training. The average length of osteopathic residency programs is 2.5 years.

There are currently 1,408 approved osteopathic intern positions and 1,688 approved residency training positions. These positions are approved by the Bureau of Professional Education of the American Osteopathic Association (AOA), the accrediting arm of our profession.

The Intern "Crunch"

The osteopathic profession is now facing a crisis regarding the long term ability of our osteopathic teaching hospitals to provide the necessary intern and residency programs needed for our new physicians. Our hospital system is not growing and, in fact, will likely be reconfigured as the pressures of Medicare and other financing programs take further hold. Osteopathic hospitals are faced with the dilemma of reacting quickly to external demands to constrain programs while meeting an increasing demand to train needed osteopathic physicians. This has resulted in an intern "crunch" in our hospitals.

Historically, about 6-7% of AOA approved intern positions nationally remain unfunded in our hospitals. In 1984, that figure has reached 13% due to declining census, shorter lengths of stay, a shift toward ambulatory services and concerns about future funding. Our profession is attempting to work out these problems within the osteopathic family, but the options are limited. Obviously, any federal or state policy initiatives that limit payment for teaching purposes will further exacerbate our problems.

Current Federal Policy

Under the present Medicare prospective payment law, osteopathic teaching hospitals are treated no differently than other teaching hospitals. It is really too early to fully evaluate how the current payment system is working in our hospitals, however, the effect on graduate medical education is being felt. In order to remain competitive, it is becoming increasingly difficult to provide quality internship programs with a significantly reduced census and an inadequate case load for teaching purposes.

The Association continues to support the exclusion of direct medical education expenses from the prospective payment system and the additional payment for indirect education expenses. We

believe that this adjustment is still needed for the same reasons that the Congress saw fit to include it when enacting the prospective payment system. Tests and procedures ordered by interns and residents, the demands placed on other staff as they participate in the education process, and other related expenses continue to be legitimate costs.

AOHA believes that any change in federal policy should await further study. Hopefully, the five-year federally funded study on the cost of graduate medical education, currently underway will be helpful in evaluating these issues. One question the study may answer is how well current case mix indexes measure the severity or intensity of cases treated in teaching hospitals. While severity of cases should be a factor in determining whether teaching hospitals should be treated differently under any payment system, we do not believe it should be the only criterion. Our hospitals are community institutions, and 90% percent of our physicians are being trained in primary care. Federal policy emphasizes the need for primary care physicians. We feel the training we are providing is consistent with that aim and should be reflected in any formula for payment to teaching hospitals.

Perspectives on Potential Policy Options

Mr. Chairman, during this early examination of possible alternatives to the current reimbursement formula for graduate medical education, AOHA would like to offer our preliminary perspectives on several general policy thrusts that have been discussed and debated informally. We realize that no formal proposals have been introduced or reviewed by the Subcommittee.

One alternative to the current payment system is the establishment of a medical education grant program, possibly in the form of a block grant to states. Under this concept, states would receive an allocation of money based on the number of filled intern and residency positions at hospitals. States would disseminate the bulk of funding directly to hospitals based on the number of training positions available. From the osteopathic hospital teaching perspective, the great disadvantage to this approach is the fact that our hospitals have a relatively small number of training slots. This could present a serious problem to such hospitals if the size of a hospital program was the basic factor considered in determining payment. We are also concerned that politics could play a large part at the state level in determining which teaching hospitals would get grants. We would urge that the established federal principle recognizing that the needs of

osteopathic hospitals be considered on a separate but equal basis be a fundamental aspect of any such program. This principle is a component of the certificate-of-need program and requires proposals of osteopathic hospitals to be judged solely on the need for osteopathic services and facilities in a given community.

Other options would limit Medicare payments to a set number of years of GME training. Three years of funding has been mentioned. The rationale is that funding limitations would cause interns or residents to gravitate to the primary care specialties. While we believe it is premature to change the system, AOHA believes this approach is worthy of close examination. Our profession's track record in producing primary care physicians is very strong and an approach that encourages this further is positive. Under such a scenario, we would suggest that the osteopathic one year rotating internship be considered separately from the first year of residency.

Another option would be to fund medical education programs through tax revenues. It could be argued that this is a fair approach since all tax payers would be subsidizing medical education. However, this would necessitate the acceptance of the principle that the country as a whole would be willing to accept the training of physicians as a national need. Again, politics could

play a part in such an approach especially in light of shifting moods regarding tax policy.

Another proposal would utilize a professional peer review process to award federal funds for medical education activities. The key for osteopathic teaching hospitals under this notion would be the identified criteria utilized in deciding which hospitals receive federal funding. Again, we feel there might be a built-in bias against the osteopathic teaching hospital in favor of the larger, academic institution. Our hospitals would need to be assured that our applications would be treated in a distinct fashion and in terms of the need for osteopathic services.

Conclusion

Mr. Chairman, the American Osteopathic Hospital Association understands that this hearing is a preliminary view of the overall issues facing medical education under Medicare. We urge that the osteopathic training model be considered in any future deliberations on these critical issues. We strongly feel that our teaching programs are producing the types of physicians that this country needs. The emphasis on primary care and providing service in medically underserved areas is a historical role of the osteopathic teaching hospital. We hope the Subcommittee will continue to consider how our alternative medical system is providing a real health care choice for the American people.

We thank you again very much for the opportunity to present our perspectives on this critical issue.

GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Group Health Association of America (GHAA) is the national association of group and staff model health maintenance organizations (HMOs). Our member plans include nearly 75% of the national HMO enrollment.

In conjunction with the Subcommittee's hearing on Medicare and Medicaid support for medical education, we have been requested to discuss HMO participation in medical residency programs and HMO relationships with teaching hospitals. We commend the Subcommittee for examining the broad range of complex issues surrounding the funding of medical education. It is a subject of great national interest and concern because policies governing the funding and types of programs will have considerable impact on the future of our health care delivery system. We appreciate having the opportunity to provide the perspective of prepaid group practice on this issue.

Several GHAA member plans participate in medical residency programs of various types. Some of these are funded entirely by dues of the members of a particular HMO and are operated by the HMO. Others are arranged by and with nearby medical schools. Residencies in family practice, primary care and subspecialties are offered.

Successful programs have been developed, notably by two well-established and highly experienced HMOs, the Kaiser Permanente Medical Care program and Group Health Cooperative of Puget Sound. The Southern California Region of Kaiser Permanente, for example, has three types of programs: Independent, Affiliated and Integrated. Under the Independent Program, the health plan develops the program and selects the trainees and the teaching staff. Affiliated Programs are provided under agreements with medical schools and universities. Kaiser Permanente provides instruction and supervision for two to four month

periods. Trainees are selected by the institution and the salaries are paid by Kaiser Permanente. The Integrated Programs are similar except that Kaiser Permanente has some voice in the trainee selection and program development. The total cost of these programs, approximately \$8 million annually, is borne by the plan.

Group Health Cooperative of Puget Sound in Seattle, Washington, has developed an arrangement with the University of Washington for providing family practice residencies.

Another approach to a medical school/HMO association is for a medical school to operate its own HMO. One example of that is the George Washington University Health Plan in Washington, D.C.

In general, HMOs are ideal settings for medical residencies because of their emphasis on ambulatory care, coordinated medical practice, internal peer review, preventive medicine and efficient utilization of inpatient care. These basic characteristics of HMOs are increasingly recognized as means by which health care can be delivered more efficiently and effectively. Therefore, health professional trainees ought to be encouraged to participate in training in prepaid group practice settings, and group practice plans should be encouraged to make available or expand medical education programs. We endorse the notion that graduate medical education be expanded to include structured training programs for care in ambulatory settings, with appropriate financial support to HMOs and other entities conducting medical education programs outside of hospitals.

GHAA has also been requested to address the relationship of HMOs to teaching hospitals.

As health care costs continue to rise, there is increasing emphasis on cost containment. Since teaching hospitals traditionally have higher

costs, they are at a disadvantage in utilization by private payors or organizations such as HMOs. It is inherent in the HMO concept to employ high quality and cost effective human and physical resources. Thus HMOs seek to avoid hospitalization if high quality alternatives are available, and they perform as many ancillary services as feasible on an outpatient basis. While HMOs often do utilize teaching hospitals for their members when and where appropriate, they tend to use quality institutions which are more cost effective than teaching hospitals. Individual HMOs must make contracting decisions which permit them to provide quality care without creating an unnecessary or undesirable financial burden on their enrollees. Indeed, even HMOs sponsored by prestigious medical education institutions utilize community hospitals when appropriate.

The HMO industry is fully aware of the high cost of medical education and its consequent financial burdens being placed on government and on teaching institutions. We are prepared to assume some responsibility for medical education costs. However we would urge the Subcommittee to consider approaches to the problem of financing medical education which would fall equitably on all citizens and health care providers.

We in GHAA support the Subcommittee's efforts to evaluate the medical education system. You may be assured that our organization will continue to cooperate with you as you strive to develop policies relating to the costs and funding of medical education as well as the kinds of programs provided and their effects on health care delivery.

TESTIMONY

on behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

and

THE ASSOCIATION OF MEDICAL SCHOOL PROFESSORS OF PSYCHOLOGY

MEDICARE AND MEDICAID SUPPORT FOR MEDICAL EDUCATION

The following statement, on the payments made by the Medicare program for medical education, is offered on behalf of the 76,000 members of the American Psychological Association, and the Association of Medical School Professors of Psychology, representing the majority of the nation's leading medical colleges. There are several aspects of the payment mechanism that concern us. One is the issue of how the payments, and changes in them, affect the training of nonphysician health professionals. The other issue is specifically for the clinical/teaching role of psychologists in the medical education process. The teaching role is not so much affected by the specific medical education payments, but by the scope of coverage allowed for nonphysician services in Medicare.

The two ways that Medicare supports medical education, the direct payment and the indirect adjustment, affect psychologists in ways that reflect the impact of this payment mechanism on nonphysician professionals.

The direct payments can be used to support the training of physicians and also for the support of "approved education programs." A facility that serves as a training site for psychology interns can, on appropriate application, include incurred costs as those of an "approved program." Psychology intern stipends paid by the hospital may then be reimbursed by the direct medical education payments. This aspect of the direct payments has not received sufficient attention in the current discussion of the ways Medicare pays for medical education.

The direct payments also go to pay faculty salary if the teaching hospital has agreed to pay them. The salaries paid are those of teaching physicians who are on hospital staff. Psychologist faculty, even though they perform the same duties and functions as physician faculty, do not receive their salary in this way. Our concern here is for the unique clinical/teaching character of both physician and psychologist teaching faculty. We would like to see a clarification in the statute that would stipulate that these payments may be made for the salaries of all clinical/teaching faculty, whether they be physicians or psychologists. We might note that, to our knowledge, no professions other than physicians and psychologists meet this doctoral level standard of joint clinical/teaching faculty status. This definition would more accurately reflect the teaching functions that occur and would assist hospital administrators to more accurately reflect the services that take place in the hospital.

The indirect adjustment, made according to a ratio of interns to beds, is used as a proxy for the patient characteristics found in a teaching hospital. It therefore covers a great many aspects of patient care, not all readily quantified, but all found in teaching hospitals. This adjustment is certainly a factor in the willingness of a hospital to serve in an affiliated teaching relationship with a medical school. Although the proxy involves physician interns, there is a subtle relationship between the existence of physician interns and the perceived ability of hospitals to support other training programs. If changes are made in the indirect adjustment, to what extent will there be an impact on the willingness of hospitals to support other health professional training programs? Hospitals are an indispensable

facility for training all types of health professionals. Indeed, professional psychologists, for example, hold tremendous promise for more efficient, more appropriate, and less expensive delivery of services. Not only is the actual supply of these professionals likely to be affected, but the experience of physicians-in-training working with other health professionals is also jeopardized. Perhaps at no other time in their professional careers will physicians be in a position to experience the same kind of "model" setting that a teaching hospital provides, because it is a teaching hospital for a variety of health professionals.

Currently, data is clearly available on the numbers of physicians involved in training. At least partly for this reason, there is some confidence in making changes in support for physicians. Previous predictions of physician shortage have now been replaced with evidence of surplus in most medical specialties. But the implications of this for other health professionals has not been fully explored. Already there are strong indications that costs will be reduced by limiting payments to support the salaries of physician interns and residents. It would be tragic if in making changes to save federal dollars based on the estimated adequacy of one class of health professional, other health professionals would suffer. For these reasons, there should be some mechanism to keep track of these interrelationships. The collection of data is of paramount importance. It is very hard to tell the exact impact of the Medicare medical education payment mechanism because of the inaccessibility or unavailability of data from the Health Care Financing Administration. For these reasons, we urge the Committee to seek answers to the following questions regarding the impact of changes with the Medicare payments.

SUBJECT: DATA ON MEDICARE PAYMENTS FOR MEDICAL EDUCATION

QUESTION: "Direct medical education payments" include as allowable costs the cost of providing approved educational activities for recognized professional programs. Non-physician programs such as those for nursing, pharmacy, and other professions are included. Institutions have also been told costs can include those for the clinical training phase of an approved psychology doctoral training program. The changes proposed so far only focus on the physician component of the payments and only pertain to physician education and training. Part of the reason for this appears to be the problem in getting accurate data on the extent of Medicare payments for non-physician education support.

What procedures does HCFA have for gathering data on the non-physician professions affected by the Medicare payments? Can data be extracted now, or are there procedures in place to make it available in the future?

Another way that the Medicare program affects psychology, and the most unique, is its impact on clinical/teaching psychology faculty. This impact is not because of the specific payments made to support medical education, but because of the way Medicare treats all non-physician services under the prospective payment system.

The Association of Medical School Professors of Psychology estimates that there are about 3,500 psychologists on the faculties of most of the nation's 128 major medical schools. This includes teaching, research and clinical faculty. We estimate that up to 1,000 of these hold the position of full-time

clinical/teaching faculty and are Ph.D. licensed psychologists in schools of medicine. They function as full-time faculty, attending on units within affiliated teaching hospitals and, in that regard, they provide a full range of administrative, teaching, and clinical services. They supervise psychiatry and psychology residents, medical students, graduate students, and house officers from other departments. Medical school departments have come to rely on psychologists to expand their curriculum and to incorporate behavioral aspects of health. In addition, their services expand and supplement organically-based, often more expensive, physician services. Departments cannot bill Medicare for the services of psychologist faculty in teaching hospitals as they can for the services of physician faculty. Both psychologist and physician faculty are required to generate clinical revenues as part of their faculty contract. We are asking the committee to let doctoral level, teaching/clinical psychologist faculty carry out their responsibilities and be paid for them in the same manner as physician clinical/teaching faculty.

The bundling provision of the prospective payment system makes it mandatory that all nonphysicians be compensated by the hospitals in which their services are performed. We have been advising psychologists generally on how to respond to this requirement. Medical school faculty, however, are often required to generate clinical revenues as part of their employment contract. A special problem occurs if there is difficulty in having the hospital pay for their services. What can happen, as we understand the situation with psychologist faculty, is one of three things: 1) The psychologist delivers the services but reimbursement is not made by the hospital. This is happening in several locations that we can identify.

Eventually, in some of these settings, the psychologists will no longer perform the services because they cannot afford to do so. The services will either be performed by someone less trained, or not performed at all. 2) The services are being performed, and billing occurs through the faculty practice plan with the psychologists' services buried under physician services. This is a theoretical possibility that would result in added costs from unnecessarily increasing physicians involvement, lost efficiencies, and complicated or duplicated administrative work. 3) The services are not being offered at all. This means, for example, that the elderly patient who needs a neuropsychological assessment to determine the extent of damage from a stroke, will receive it from someone likely unskilled, with future costs of greater magnitude to repair, if possible, damage that might occur.

This restriction on billing prohibits an accurate reflection of the service system by the reimbursement mechanism. It is often wasteful and causes unnecessary repetition in service reimbursement. In order to clarify the extent of this problem, we would like the committee to explore the following questions.

SUBJECT: CLINICAL REVENUES AND MEDICAL SCHOOL SUPPORT

QUESTION: In addition to earmarked payments, Medicare supports medical education by reimbursing for the clinical services of medical school faculty in teaching hospitals. These payments provide a source of revenue for medical schools. Faculty members are able to generate them by billing

either independently, or through a mechanism such as a faculty practice plan. What is the position of this source of revenue as a percentage of medical school budgets, and is it increasing or decreasing?

How has this source of revenue been affected by the prospective payment system?

Does the rebundling provision of the prospective payment system affect the ability of non-physician faculty members to generate revenues whether or not they are members of a faculty practice plan?

A solution to this situation would be to allow all clinical/teaching faculty in medical schools to bill directly for their services. This would include Ph.D. licensed psychologists who deliver services in teaching hospitals as part of their faculty contract.

To summarize, we have two concerns: one is the impact any changes in the amounts or mechanism of the Medicare medical education payments would have on the education and training of non-physician health professionals. We would like to see more attention paid to this issue in the current discussions on changes in the ways Medicare supports medical education. We have suggested a specific question to assist in clarifying what data might be available to assist in this process. In addition, we are concerned about the position of psychologists in clinical/teaching positions as full-time medical school faculty because of the restrictions in reimbursement under Medicare for the services of nonphysicians. We would like to see psychologist faculty able to

be reimbursed for their services in the same way as their physician peers. This would avoid unnecessary and likely repetitious administrative or clinical requirements and associated costs. We have suggested a direct way to accomplish this, through statutory change, and urged the Committee to clarify the importance of clinical revenues in medical school budget support. The straightforward reporting of reimbursable services would also enable the reimbursement system to more accurately reflect the health care service delivery system. If changes are made in other mechanisms of support for medical education, it will be imperative that medical schools be able to predictably use other resources to guarantee their own fiscal stability.

Thank you for the opportunity to present our concerns.



American Association of Colleges of Nursing

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Introduction

Medicare (Title 18) was established to assure the provision of health care services to the elderly. The majority of Medicare services are provided in hospitals, nursing homes and private and public home health agencies. Since Medicare reimburses health care providers for services given to recipients, the government has a rightful interest in assuring that appropriately qualified health professionals provide service which is both of high quality and cost-effective. This interest has been recognized in the pass-through mechanism for hospitals where the bulk of care is provided. It is well known that nurses provide a large share of the professional health care rendered to the elderly in our society, it must be assumed that nurses will continue to provide a large share of care to recipients. Physicians alone cannot meet this need. Currently, questions have been raised as to whether education of physicians, nurses and other health care professionals should continue to be subsidized by Medicare dollars and, if so, at what level of support. To ensure a continuing supply of qualified nurses to meet the health needs of Medicare recipients, in any redesign of Medicare regulations, serious consideration should be given to developing policy that will support nursing education in a more rational manner than in the past when only ad hoc approaches have prevailed.

Policy

The AACN recommends that HCFA continue reimbursement for nursing education through Medicare dollars, at least at the current level which is reported in the 1983 IOM Study to be in the neighborhood of 350 million dollars. A rational plan

for redistribution of the nursing education dollar means directing Medicare funds to clinical graduate nursing education, i.e., those programs in which a Registered Nurse is enrolled in a graduate degree granting program in nursing and provides clinical service to the elderly. Master's and doctoral programs in nursing are included within the category of clinical graduate nursing education. It is increasingly recognized that professional preparation for nursing is taking place in degree granting institutions, many of which have strong ties with university and community teaching hospitals.

Hospitals or educational programs should bill and be paid for service given the elderly by students and faculty and for the salaries and other costs associated with the supervision of clinical experiences of graduate nursing students. Those portions of clinical graduate nursing education programs that are carried out in hospitals and other clinical agencies that provide services to Medicare patients should be supported.

Rationale

The justification for requesting support of the clinical training which occurs in the graduate nursing programs is concerned with the fact that clinical teaching cannot occur in the absence of service to patients. The inclusion of practical patient care experiences is central to clinical graduate nursing education. Supervision is provided by faculty members who are experienced in the field, and students provide service to patients while obtaining an education. The students are fully licensed R.N.s who have decided to return to school to advance their professional education. Nursing students must pay tuition, but they receive

no stipends for the service they provide patients. A limited amount of scholarship assistance is available from the government or voluntary agencies. Federal funds to support specialty education have decreased rapidly, particularly for Master's degree students. Since a high portion of Master's programs are designed to prepare clinical nurse specialists in various settings such as primary care and gerontology, it is reasonable and appropriate that Medicare dollars support these services. Patients benefit directly by the care given by graduate nursing students. The society as a whole also benefits from the maintenance of an adequate supply of providers and a high quality of education for nurses.

It is abundantly clear that nursing school faculty differ in significant ways from faculty in other health care professions. Nursing faculty have not been privileged to be included in fee for service arrangements. They have generally not been able to call upon graduate students to assist with the training of graduate students. The time and effort spent by nursing faculty who supervise students in clinical experiences should be viewed as making a significant contribution to service, but this has not been the case. In most cases, faculty salaries are paid in full by colleges and universities even though a significant percentage of their time and effort is devoted to service activities in hospitals. A similar policy has been in place for the training physicians for many years. However, the nursing community has benefitted only minimally for similar efforts directed at caring for the elderly. Nursing faculty time and effort spent in supervision of clinical graduate nursing education students and in the provision of direct service to patients should be reimbursed

by Medicare.

The AACN policy recognizes that Medicare dollars for nursing education historically have been attached to hospital financing. The intent of AACN is to ensure continuance of the flow of these funds to hospitals, not only to improve in-hospital clinical services, but also as an attempt to free up financial resources that should be used for ambulatory and home health services provided by nurses. Financial support should be given by the public sector, the private sector, students, patients and third party payors. With multiple sources of funding available, access to high quality health care and health care education will be maintained. Nursing has recognized the changing demographic and economic environments and has moved quickly to provide needed service to the elderly population. With adequate financing from Medicare, nursing education can continue this responsiveness to the needs of the elderly.

National League for Nursing and

American Nurses' Association

The National League for Nursing (NLN) and the American Nurses' Association (ANA) commend you and your Committee for your attention to the subject of clinical education programs for the health professions. The NLN is the accreditation body for nursing education and includes 2,000 agency members and approximately 17,000 individual members; the ANA represents 185,000 registered nurses through 53 constituent state nurses associations. We are writing to share with your Committee the views of our organizations and request that these comments be included in the record of your April 4, 1985, hearings.

Your focus at these hearings is on the post-graduate education of physicians. In several respects, however, the education of nurses and other health professionals must be considered as you evaluate health manpower needs and the most appropriate financing mechanisms for these programs. In fact, actions that may be taken with respect to physician education support could have very profound effects on nursing education in the hospital setting.

By way of background, it is important to recognize that Medicare payments to teaching hospitals for the direct costs of educational programs include funds for nursing education and the training of many other professions, as well as the costs of graduate medical education (GME). At this time, there are few data available on the proportion of Medicare's payments that is applied to non-physician health professions programs. The NLN is currently conducting a survey of nursing educational programs to gain more precise estimates of the costs of clinical programs in nursing and the contribution made by Medicare. We will share these data with the Committee and other interested parties.

Conditions for future Medicare funding of GME based on the assessments of the physician needs of Medicare beneficiaries or on the nation as a whole should not apply to nursing education programs. These matters simply are not germane to Medicare's policy on nursing clinical education programs.

Meanwhile, we do know that the nursing component of overall Medicare educational payments to hospitals is proportionately small. Yet, these funds are critical to the financial viability of many programs. It would be unfortunate, indeed, for these clinical education programs in nursing and the allied health professions to lose or receive reduced Medicare contribution to direct educational costs because of policies designed for and aimed at GME programs.

There is, in our view, not nearly so clear a consensus concerning the adequacy of the supply of registered nurses as there seems to be with respect to physician resources. On the contrary, we believe that in particular specialties and in the case of advance prepared practitioners, there are serious shortages and a maldistribution of nursing manpower. With the dramatically changing health system resulting in more acutely ill hospital patients, an explosion in ambulatory health services, and a growing demand for post-acute and home care, it would be difficult to justify reductions in Medicare's funding of nursing education on the grounds of an oversupply of nurses.

It is also important to note that hospitals with large graduate medical education programs do not always have large nursing education programs, and vice versa. Nursing and physician education programs are developed by different schools and are often operated by separate institutions with different goals and resources. They relate to each other by virtue of sharing the resources and responsibilities of a teaching hospital. Thus, reduced GME Medicare payments to a hospital under some future provision of law could seriously jeopardize a nursing education program operating in the same institution, and the effect on the nursing program would not necessarily have been considered in formulating such policies.

Nursing, like other health professions, is going through a period of profound change adjusting to new trends toward less hospitalization and more ambulatory and primary care. However, the responsiveness of nursing educational programs to changing consumer demands present a very different picture from those of graduate medical education programs. Basically, because the demands for nursing are different than those for medicine. We would urge, therefore, separate consideration be given to both the need for nurses and the urgency and form of any government incentives under Medicare. Conclusions about what Medicare should pay for physician education in the clinical setting should be separate and distinct from policies that may be developed for nursing programs.

Given these factors, the National League for Nursing and the American Nurses' Association urge that you apply your conclusions regarding Medicare payment toward graduate medical education only to those programs involving physicians, and continue to recognize and pass-through the costs of nursing and other health professions programs. If, at some point, your Committee wishes to review the future need for nurses, the types and extent of training that would be appropriate, and Medicare's responsible share of these costs, we would be glad to be of assistance.



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FEDERAL FUNDING FOR HEALTH PROFESSIONS EDUCATION

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NOTE: This paper was prepared at the request of the Subcommittee on Health and the Environment, House Committee on Energy and Commerce.

BACKGROUND

Health Professions Education

Health education programs for the training of physicians, nurses, and allied health personnel combine classroom training and learning through "hands on" experience. Classroom training is often conducted in a university setting and the "hands on" or clinical training is generally hospital-based.

Medical Education

Contemporary medical education (the training of physicians) generally includes the completion of four years of medical school and a residency program lasting three years or more. The four years of medical school education are often referred to as undergraduate medical education, even though most medical students enter medical school after completing four years of study at an undergraduate institution. Residency training, which begins after the completion of medical school and the award of the medical degree, is referred to as graduate medical education.

Typically, the first two years of undergraduate medical school training consist of classroom instruction in the basic sciences, including anatomy, biochemistry, physiology, pharmacology, and pathology. Most of this instruction is provided in the classroom at the medical school.

Although most students have at least some clinical experience during the first two years of medical school, the bulk of clinical training for the

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medical school student is provided during the last two years of undergraduate medical education. The length and number of required clinical education periods, known as clinical clerkships, vary from school to school. As part of a student's exposure to clinical medicine, clerkships are usually required in internal medicine, obstetrics-gynecology, pediatrics, psychiatry, and surgery. Clerkships vary in length from two to 12 weeks. During clerkships, students are usually assigned to a hospital service where they assume responsibility for assessing and presenting to the faculty a specified number of cases each week. Students also participate with post-M.D. trainees (residents) and faculty in caring for patients admitted to the clinical service to which they are assigned.

After completing undergraduate medical education and receiving the professional degree, most physicians enter graduate medical education programs, also known as residency training programs. Graduates of medical schools must enter residency training programs for a variety of reasons. First, most States require at least one year of graduate medical education to be eligible for a license to practice medicine. In addition, residency training is required for a physician to be certified as a specialist in a given area of medicine.

In 1984, there were approximately 75,000 residents in training in 4,800 approved residency training programs. Residency training programs are approved and accredited in one of two ways: (1) by the Accreditation Council for Graduate Medical Education (which is composed of representatives of the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Speciality Societies) upon recommendation of an appropriate residency review committee (RRC) which consists of representatives appointed by the American Medical Association, a particular specialty board,

and in some cases, a national specialty society; or (2) by the RRC itself if accreditation authority has been delegated by the Accreditation Council for Graduate Medical Education. Accreditation of a residency program indicates that it is in substantial compliance with published general requirements for graduate medical education and special requirements for training in a particular specialty.

Generally, residency training programs are offered by hospitals, and the resident is paid a stipend for participating (approximately \$20,000 per resident in 1984). However, in the course of completing a program, residents in some specialties such as preventive medicine, occupational health, and family practice may be assigned to clinics or ambulatory centers not associated with hospitals.

During residency training, knowledge and skills acquired in medical school are expanded through increasing personal responsibility for patient care in a structured and supervised clinical education environment. Residents in hospital-based graduate medical education programs, known as house staff members, provide care for patients, further their own education, and teach medical school students. As residents progress through their training programs, they gain considerable autonomy and responsibility for providing patient care services.

Residency training is organized by specialty (e.g., internal medicine, surgery, etc.). As noted above, for each of the approximately 25 medical specialties, various requirements have been established for residency training programs and for certification as a specialist upon completion of training. Training requirements include the content and length of residency programs. Residency programs vary in length according to specialty and typically last from 3 to 7 years. Specialties such as family medicine, internal medicine, pediatrics, and surgery encourage students to enter their residency training programs directly after completing medical school and to continue in these

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programs until they have completed specialty board requirements. Satisfactory completion of three years of training in family medicine, internal medicine, or pediatrics generally qualifies a doctor to sit for examination by the certifying boards of these specialties. Surgery requires five or more years of training depending on the subspecialty of surgery chosen.

Students seeking careers in other specialties are encouraged or required to spend their first graduate year in a residency program offering a broad clinical experience. Examples of these specialties are anesthesiology, dermatology, psychiatry, and radiology. Usually these students apply for a single year of internal medicine or for a diversified, traditional first graduate year with the expectation that they will enter a program in the specialty of their choice in their second graduate year. In some cases, a year of broad clinical experience may be located in the same institution where subsequent specialty training occurs. In other instances, specialty training must be completed elsewhere.

Foreign Medical Graduates

Graduates of foreign medical schools may participate in U.S. graduate medical education programs. These foreign medical graduates (FMGs), currently approximately 13,000, include (1) non-citizens who enter temporarily as exchange visitors for residency training and who return to their countries upon completion of training; (2) U.S. citizens who graduate from foreign medical schools; and (3) non-citizens who are admitted permanently as immigrants to the U.S.

The percent of FMGs in graduate medical education has dropped from its peak of 33 percent in 1970 to 18 percent in 1984. The 1976 Amendments to the Immigration and Nationality Act (P.L. 94-484) resulted in a decrease in the

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number of new exchange visitor physicians allowed to participate in residency training programs. In academic year 1973-74, more than 2,900 new exchange visitor physicians became eligible for residency training. In contrast, only 544 new exchange visitor physicians became eligible in 1981-82. Across all years of residency training, only 1,552 exchange visitor FMGs were in graduate medical education positions in 1981-82, as compared to over 8,000 in 1973-74.

Despite this decline, the number of U.S.-citizen FMGs (USFMGs) increased substantially. USFMGs in graduate medical education rose from 4,229 in 1979 to 7,314 in 1984. These figures reflect an increase of 73 percent in the number of USFMGs participating in graduate medical education. Proportionally, USFMGs represented about 35 percent of all FMGs in 1979 compared to 55 percent in 1984.

Nursing Education

Nursing education has evolved from what was once primarily three years of hospital-based training to several curricula which are becoming more closely affiliated with or sponsored by colleges or universities. While the classroom training is now more likely to be in a college or university, hospitals remain the primary sites for the undergraduate clinical training of nurses.

Three types of programs awarding different credentials prepare their graduates for licensing as registered nurses: diploma, associate degree, and baccalaureate degree programs. As of October, 1982, there were 1,432 State Board-approved programs of registered nursing education in the country.

Diploma programs, which generally are 3 years in length, are usually based in hospitals. Until the 1970's, the diploma program was the primary source of training for students to enter nursing and graduated the majority of registered

nursing students in any one year. The number of diploma programs has been declining steadily during the last two decades, as a result of demand by nurses for professional degree programs in institutions of higher education. In 1961, there were 875 diploma programs; as of October 1982, there were 288. Generally, students in diploma programs receive classroom instruction and spend three to four semesters in clinical training, which takes place most often in general care units of a hospital.

The newest of the three types of programs training registered nurses is the associate degree, primarily 2 years in length and located mainly in junior or community colleges. The first such programs were organized in the early 1950s, and their number continued to grow rapidly through most of the next decade. Starting in the early 1970s, the number of associate degree programs continued to increase but at a much lower rate than in their early developmental years. As of October 1982, there were 742 State Board-approved associate degree programs, compared with the 69 which existed in 1961. Generally, students enrolled in associate degree programs receive classroom instruction and spend three semesters in clinical training and, like diploma degree students, spend this time in general care units of a hospital.

The third type of program preparing students for licensure as registered nurses is the baccalaureate program. These programs generally require four years of study; however, a quarter of these programs are only two years in length since they first admit students in their junior year; another quarter are three years in length, admitting students to the program in their sophomore year; and half are four-year programs admitting students in their freshman year. While nursing programs leading to a baccalaureate degree have been in operation since the 1920s, the growth of these programs increased steadily beginning in

the 1960s and continuing throughout the next two decades. In October 1982, there were 402 baccalaureate programs, as compared with 173 such programs in 1961. Generally, students in baccalaureate programs spend four to five semesters in clinical training. Most of this training takes place in the hospital, including critical care units as well as general care units of the hospital. In addition, a significant portion of the clinical training of the baccalaureate student takes place in community health agencies, home health agencies, nursing homes, and other outpatient settings.

Basic nursing education provides a foundation for practice as a registered nurse. Advanced nursing positions (for example, clinical specialist, supervisory/administration, or teaching) require training beyond the registered nurse level. While the majority of nurses have not continued beyond their initial nursing education, about 13 percent, or 213,000 registered nurses, are estimated to have graduated from additional academic programs. These programs consist generally of classroom instruction as well as clinical training. The length and site of the clinical training for advanced nursing positions varies by program and specialty. For example, the clinical training of a clinical nurse specialist will often take place in the intensive care unit of a hospital. A family nurse practitioner, on the other hand, will spend little time in clinical training in the hospital (generally in the outpatient department), but rather will have a community agency or doctor's office as the principal site of clinical training.

In addition to training programs for registered nurses and advanced nursing positions, other programs prepare licensed practical nurses to provide nursing services under the supervision of a registered nurse or physician. As of October 1982, there were 1,295 State Board-approved programs preparing students

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to become licensed practical nurses. The majority of practical nursing programs are located in trade, technical, or vocational schools. About three out of ten are in junior or community colleges, while some are in hospitals and some in secondary schools. The number of programs located in hospitals has been declining; some 15 percent of programs in 1971 were in hospitals and only eight percent in 1981, the last year for which such data were available.

Allied Health Education

Allied health personnel include technologists, therapists, and others who perform relatively high-level health care functions, technicians and assistants whose duties vary greatly in complexity, and aides who perform routine supportive services. Allied health occupations include dietitians, physical therapists, speech pathologists, laboratory technicians, and nuclear medicine technologists. These, however, are only a few of many allied health occupations. One survey identified 141 health occupations that can be considered allied health by some definitions. The range of services rendered by allied health professionals includes emergency services, initial evaluation, treatment, therapy, testing, fitting of medical devices, record maintenance, acute care, long-term care, and rehabilitation.

Because of this variety in function, the scope of allied health education is similarly broad, ranging from limited postsecondary training to postdoctoral training. According to the 1984 Report to the President and Congress on the Status of Health Personnel in the United States by the Bureau of Health Professions, Department of Health and Human Services (DHHS), it is not possible with certainty to inventory all allied health training programs, academic and nonacademic, accredited and nonaccredited. However, this report estimates

that in 1979-80, there were approximately 475,000 students enrolled in allied health education programs in all settings, including collegiate and non-collegiate settings. A 1979-80 survey of collegiate allied health programs indicated that approximately 325,000 students were enrolled in allied health educational programs in collegiate settings. Only rough approximations of enrollments in programs in other institutions can be made: 65,000 in hospital-based programs, 40,000 in military programs, and 45,000 in other nonmilitary settings, such as vocational-technical or proprietary schools.

The length of a program a student must complete to qualify for entry into an allied health occupation varies by occupation. However, training for most allied health occupations follows the general model of classroom and clinical training. For collegiate programs, the most commonly used clinical facility is the hospital. However, many programs are affiliated with other settings; for example, programs for occupations with both a patient care and health promotion focus (dental hygienist and various types of therapists) tend to expose their students to a variety of settings outside the hospital.

Health Professions Education in Hospitals

Characteristics of Teaching Hospitals

Clinical training for both undergraduate and graduate health professions education in this country is generally conducted in the hospital setting. Approximately 18 percent of all U.S. hospitals offer teaching programs, which vary considerable in terms of their size and diversity. Teaching hospitals may have programs for the training of physicians (generally called graduate medical education, conducted through residency programs), nurses, or such

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allied health personnel such as dietitians, emergency medical technicians, occupational therapists, and physical therapists. The principal focus of this paper is on graduate medical education because these programs are the most costly for the teaching hospitals. In addition, very little data exist on the costs to hospitals of nursing and allied health programs.

The number of teaching hospitals in the country depends on the definition of teaching hospital used. Approximately 1,200 hospitals (18 percent of all U.S. hospitals) participate in at least one residency program. Approximately 1,100 of these hospitals are affiliated with medical schools. Approximately 400 of these teaching hospitals meet the requirements for membership in the Council of Teaching Hospitals (COTH) of the Association of American Medical Colleges, which include sponsorship of at least four approved residency programs ^{1/} and recommendation for membership by an accredited medical school with which the hospital is affiliated. Although data gathered by COTH from its members represent teaching hospitals with major graduate medical education programs and understate the number and variety of teaching hospitals in the country, little data about other teaching hospitals exist.

Major teaching hospitals are generally committed to at least three distinct objectives: 1) providing patient care, 2) training health professionals, and 3) conducting clinical research. The interrelationship of these three activities within the teaching hospital creates an institution which is in many ways different from the single purpose non-teaching hospital. This interrelationship also makes it difficult to separate the health professions education activities of a teaching hospital from its other activities, particularly

^{1/} That is, those accredited by the Accreditation Council for Graduate Medical Education or by the Residency Review Committee for the specific clinical specialty.

patient care. Each of these objectives of the teaching hospital is discussed in more detail below, using 1980 data from the COTH on its member hospitals.

Patient care. Most major teaching hospitals are large hospitals (75 percent of COTH hospitals had over 400 beds, compared to only 7 percent of non-COTH hospitals). Most COTH hospitals (75 percent as compared to 55 percent for non-COTH hospitals) are nonprofit entities located in urban areas (97 percent of COTH hospitals compared to 47 percent of non-COTH hospitals). COTH hospitals are concentrated primarily in the Northeast region of the country. Although COTH hospitals represented only 6 percent of all short-term non-Federal hospitals in 1980, they accounted for 18 percent of admissions, 21 percent of the births, and 30 percent of the outpatient visits. COTH hospitals on average employed almost six times the number of full-time equivalent personnel employed in non-COTH hospitals.

Teaching hospitals provide a wide range of hospital services, many of which (such as burn care units, organ banks, and open heart surgery) are typically unavailable in nonteaching community hospitals. Patients with the most severe medical problems tend to be referred to teaching hospitals for the latest techniques and equipment used in patient care. Teaching hospitals have historically played a major rôle in providing care for economically disadvantaged patients (COTH members admitted 18 percent of the country's patients but 25 percent of the Medicaid admissions) and had a higher-than-average share of patient bad debt and charity care (bad debt and charity care represented 9 percent of patient revenues in COTH hospitals in 1980 compared to 5 percent in non-COTH hospitals).

Clinical education. The teaching hospital is the setting for most of the clinical training for health professions in this country. According to

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American Hospital Association data for 1983, U.S. hospitals provided training sites for approximately 71,000 medical and dental residents and for 9,000 other trainees, including nurses, technicians, and medical students in their last two years of medical school. In 1983, 1,200 hospitals had residency programs and 280 had professional nursing schools. In 1980, the 400 COTH hospitals trained 71 percent of all residents and 36 percent of all nursing and allied health trainees.

Historically, hospitals providing the opportunity for medical school graduates to gain practical experience were not affiliated with, or owned by, medical schools. Today, however, although free-standing residency programs may still be established, staffed, and controlled by an individual hospital, more commonly there exists some affiliation between the medical school and the teaching hospital. The term "academic health center" has been used to describe a constellation of institutions which provide undergraduate and graduate training in a variety of health professions. An academic health center can include medical schools, teaching hospitals, and often other professional and allied health schools, biomedical research institutions, ambulatory care centers, rehabilitation institutes, and health maintenance organizations. Although the affiliations between teaching hospitals and medical schools vary considerably, they emphasize the fact that the period of practical experience in a teaching hospital is considered an essential phase in the medical education of a physician.

Clinical research and applied technology. Many advances in the medical sciences began in the basic research laboratories of universities and their affiliated hospitals and were then applied to patient care in clinical research programs at teaching hospitals. While most of the nation's clinical research takes place in teaching hospitals, not all teaching hospitals are

equally involved in the medical research process. Generally, involvement in medical research projects is extensive where the hospital's medical staff is composed primarily of full-time faculty physicians. Medical research is typically less extensive where the hospital's medical staff is composed of physicians in private practice. A major commitment on the part of a teaching hospital to medical research results in certain managerial and financial implications for the hospital. For example, research programs often alter the mix of services and the cost of care for patients in experimental care programs in teaching hospitals compared to non-teaching hospitals.

Measuring the Cost of Health Professions Education in Hospitals

The costs of delivering patient care in teaching hospitals are consistently higher than in non-teaching hospitals. Simple cost comparisons, for example, show that in 1981 the average cost of care in COTH hospitals was \$3,281 per adjusted admission, nearly twice as high as the average of \$1,683 in non-COTH hospitals. These cost differences reflect many of the differences in objectives and other characteristics (such as location and size) between teaching and non-teaching hospitals which were described earlier in this paper.

Teaching hospitals incur additional costs because of their educational activities: faculty, support staff, and residents must be paid; conference and classroom space must be included in the hospital plant; and additional equipment and supplies must be purchased. The costs of these activities, known as the direct costs of health professions education, are generally identifiable and separable by standard accounting methods from the costs of patient care in the hospital. The direct costs of graduate medical education have been estimated to be between \$1 and \$3 billion nationwide. The average amount that a COTH member hospital spent on resident stipends and benefits in 1983-1984

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was \$3.2 million, or approximately 4 percent of the average COTH hospital's total operating budget.

In addition to the direct costs of medical education, the presence of teaching activities can indirectly affect a hospital's costs. These indirect costs can arise from reduced productivity in patient service departments (e.g., treatment takes longer, demands on other staff are greater), increased overhead for such activities as the keeping of medical records, increased complexity of hospital management, and the tendency of residents to provide more services and to conduct more tests than experienced licensed physicians.

In addition, there are other factors that may account for the cost differences between teaching and non-teaching hospitals which may not be directly related to the teaching activity. These factors, which are not currently separable from the indirect costs of medical education, may include patients who are more severely ill, clinical research, more sophisticated and expensive medical technology (with perhaps the added cost of "idle" time or "standby" capacity for infrequently used services), higher and more specialized staffing levels, and perhaps less efficient operation. Many of these factors are related to differences in the complexity of the mix of patients (known as case mix) treated and the diversity and sophistication of the services offered in teaching hospitals versus non-teaching hospitals, rather than to the actual teaching activity itself.

The indirect costs of health professions education in teaching hospitals are difficult to separate from total operating costs and to quantify because patients are being treated and students are being trained through the same patient care activities. Although data show that teaching hospitals have costs per admission that are twice as high (100 percent higher) as those in

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non-teaching hospitals, few studies have attempted to account for this difference. The direct costs of health professions education programs account for only approximately 10 percent of the difference in costs between teaching and non-teaching hospitals. Thus, approximately 90 percent of the difference remains to be accounted for. Due to the limited analyses of indirect medical education costs, it is unclear whether the remainder can be attributed to the indirect costs of the medical education activity or must be attributed to other characteristics of the teaching hospital.

Some studies have suggested that indirect costs may be quite large. For example, as part of a study on the Financing of Medical Education conducted by Arthur Young and Policy Analysis, Inc., for the Department of Health and Human Services, total costs per admission were analyzed for patients in four diagnostic categories at seven teaching and two non-teaching hospitals. A 1983 pilot report from this study indicated that, on average, the direct and indirect costs of graduate medical education accounted for more than 40 percent of the costs per admission in the teaching hospitals studied. Most of the observed difference in cost was attributed to the indirect costs of graduate medical education, primarily the greater use of ancillary tests and procedures. Further analysis of a subset of patients for whom severity of illness had been measured indicated, however, that some portion (but not all) of the difference might be attributed to differences in severity of illness. Other studies have shown a wide range of results in estimating the contribution of indirect teaching costs to total costs in teaching hospitals. Due to the limitations of the available studies, however, the size of indirect costs remain unclear. Results from the Arthur Young study, to be completed later this year, should be helpful in this analysis.

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Another study of graduate medical education underway is that commissioned by the Commonwealth Fund Task Force on Academic Health Centers. The study has three components: the Future Financing of Teaching Hospitals (using secondary analyses of existing data); the Size, Content and Cost of Graduate Medical Education Programs; and the Role of Teaching Hospitals in the Care of the Poor and the Uninsured. This study should be completed this summer.

Using broad estimates from several sources, the total costs to hospitals of their graduate medical education activities range from \$4 to \$9 billion nationwide, with \$1 to \$3 billion estimated for direct costs and \$3 to \$6 billion for indirect costs. These amounts represent approximately one percent to two and one-half percent of the \$355 billion spent nationally for health in 1983. Although these numbers represent the major portion of hospital costs for health professions education in this country, they understate total spending to the extent that they exclude the costs of nursing and allied health programs, for which data are not available.

Sources of Financing for Health Professions Education

Overview

A variety of sources exist for financing health professions education. For undergraduate medical education, support is available for student assistance, primarily through Federal loans and loan guarantees, and Federal and private scholarships. Medical schools receive financial support from Federal research awards, State and local government appropriations, the professional fees generated by faculty members from their patient care activities, and Federal grants available under the Public Health Service Act for special

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education and training programs. Teaching hospitals receive support for health professions education programs primarily through revenues received for patient care.

Student support. Undergraduate students receive support from the following sources:

Non-borrowing (the source for 12% of medical school seniors in 1984)

- * Personal or family resources
- * Service contingent scholarships, including Armed Forces and National Health Service Corps, and State and other scholarships
- * Other scholarships, including school funds

Borrowing (the source for 88% of medical school seniors in 1984)

- * Private sources with Federal guarantees, including the Guaranteed Student Loan Program and Health Education Assistance Loans
- * Matching revolving funds, established jointly with Federal and school resources, including Health Professions Student Loans and National Direct Student Loans
- * School loan funds
- * Private conventional loans

Support for medical schools. Medical schools receive support from both government and non-government sources to operate programs in education, research, and patient care. Federal research awards are a major source of revenue (approximately 20 percent of total medical school revenues). Other sources of Federal support (5 percent) include awards for training, education, and service programs (for example, those available under the Public Health Service Act). Public medical schools derive a substantial amount (36 percent) of their revenues from State and local government appropriations (only 4 percent for private medical schools). Tuition and fees account for about

6 percent of medical school revenues. The remaining identifiable portion of revenues comes from medical service revenues (40 percent for private medical schools and 26 percent for public medical schools), which come primarily from the professional fees generated by faculty members from their patient care activities.

Support for teaching hospitals. Patient care revenues are the primary sources of support for both patient care activities and health professions education programs in teaching hospitals. For example, according to 1983-1984 data on COTH member hospitals, 81 percent of the costs of residency stipends and fringe benefits were derived from patient care revenues. Other sources included State appropriations earmarked for residency expenses (5 percent), Veterans Administration appropriations (2 percent), medical school/university funds (2 percent), municipal appropriations earmarked for residency expenses (1 percent), and physician fee revenues (1 percent). Foundation grants and voluntary agencies, NIH, other Federal agencies, endowment income, and other sources of support made up the remaining 8 percent of total residency support in teaching hospitals.

Support of health professions training in hospitals through patient care revenues has historically been considered appropriate since such training is produced jointly with patient care. Teaching hospitals have routinely included the costs of these training programs along with their other expenses in determining their total costs of producing hospital services and in setting their charges for services. These costs also have been included in the rates paid for patient care by payers of hospital services (known as third-party payers), including Medicare, Medicaid, Blue Cross, and the commercial health insurers. Health professions education in hospitals has thus been subsidized by the third-party payers, who obtain their funds for patient care payments from employer/employee payroll taxes (Medicare), Federal and State tax revenues

(Medicaid), and employer/employee/enrollee premium payments (Blue Cross and commercial insurers).

Medicare Payments for Health Professions
Education in Hospitals

Since its inception, the Medicare program has recognized in various ways in its reimbursements to hospitals certain expenses associated with the operation of approved health professions education programs. Although not required by law, congressional intent indicated that the Medicare program should pay its share of the net cost of education activities conducted in hospitals until the community undertakes to cover these costs in some other way:

Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program. ^{2/}

Medicare regulations (CFR, Title 42, Sec. 405.421) indicate that a provider's (e.g., a hospital's) allowable costs for purposes of Medicare reimbursement may include the net cost of approved educational activities. Net cost is defined as a provider's total direct and overhead costs of approved educational activities (including trainee stipends, compensation of teachers and other direct and overhead costs, minus revenues the provider receives from tuition.

^{2/} U.S. Congress Senate. Social Security Amendments of 1965. Report of the Committee on Finance to accompany H.R. 6675 to Provide a Hospital Insurance Program for the Aged . . . June 30, 1965. Washington, U.S. Govt. Prin Off., 1965. (98th Cong., 1st Sess. Senate Rept. No. 404, Part I), p. 36.

Approved education activities are defined by regulation as formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law; where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity. Approved programs include medical, osteopathic, dental, and podiatry internships and residency programs, recognized nursing programs, and allied health education and training programs including cytotechnology, dietetic internships, hospital administration residencies, inhalation therapy, medical records, medical technology, nurse anesthetists, professional nursing, practical nursing, occupational therapy, pharmacy residencies, physical therapy, and x-ray technology.

Payment Under Cost-Based Reimbursement. When the Medicare program began in 1966, Medicare paid its proportional share of a hospital's health professions education costs together with other allowable costs under Medicare's cost-based method of reimbursement. Over the years, as the Medicare program began to establish limits on the amounts it paid to hospitals, the costs of medical education received special consideration.

Under authority contained in Section 223 of the Social Security Amendments of 1972, the Department of Health and Human Services (then the Department of Health, Education and Welfare) began in 1974 to establish annual cost limits on reimbursement of certain routine hospital costs (generally, the costs of room, board, and routine nursing care). The higher routine costs of hospitals with significant medical education activities were recognized by the Medicare program in 1975 when an exception to the routine hospital cost limits was allowed if a hospital could demonstrate that it exceeded its cost limits

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because of the costs of its educational activities, to the extent that such costs were atypical compared to those of other similar hospitals.

Explicit allowance was made for medical education costs, effective with hospital cost reporting periods which began July 1, 1979, when the direct costs of approved medical education programs were excluded from the routine costs subject to the Medicare hospital cost limits. The direct medical education costs were excluded so that the basis on which the cost limits were applied in teaching and non-teaching hospitals would be comparable.

On April 1, 1980, the Department proposed that an additional adjustment for the indirect costs of medical education programs be made to Medicare's hospital routine cost limits. The proposed regulations stated that:

Generally, hospitals with approved graduate medical education programs incur higher per diem operating costs than non-teaching hospitals of similar bed size and geographic location We believe these increases in per diem cost occur because the provision of graduate medical education causes increases in certain types of costs that are only indirectly related to education programs. . . . To prevent a disproportionate number of teaching hospitals from being adversely affected by the limits, we have, in the proposed schedule, provided an automatic adjustment for the costs generated by approved medical education programs. Based on the data we used to derive the proposed limits, we have estimated that a hospital's general inpatient routine operating costs may be expected to increase by a factor of .047 (4.7 percent) for each increase of .1 (above zero) in the ratio of its full-time equivalent (FTE) interns and residents (in approved programs) to its number of beds. 3/

It should be noted that the proposed regulations stated that to obtain this adjustment, a teaching hospital would not be required to identify explicitly the costs for which the adjustment was being made. Instead, the hospital would be required to report only its number of full-time equivalent interns and residents in approved programs (i.e., those employed more than 35 hours or more

3/ Federal Register, April 1, 1980, p. 21584.

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per week and one-half of those employed less than 35 hours per week in the hospital) which, together with the hospital's bed size, would be used to compute the percentage by which the hospital's reimbursement limit would be increased. This medical education adjustment, which later became known as the indirect medical education adjustment, became effective for hospital cost reporting periods which began on July 1, 1980.

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248, known as TEFRA) made certain changes in the hospital routine cost limits, including expansion of the limits to cover total inpatient operating costs (not just routine costs) so that ancillary and special care unit costs were included. Because more of a hospital's costs were now included under the limits, the limits effective for hospital cost reporting periods beginning on October 1, 1982, included an increase in the percentage amount of the indirect medical education adjustment from 4.7 percent to 6.06 percent.

TEFRA also created a new ceiling on the allowable annual rate of increase in total inpatient operating costs per case for inpatient hospital services. . As with the hospital cost limits, these new rate-of-increase limits excluded the direct costs of approved health professions education programs.

Payment Under the Prospective Payment System. Title VI of the Social Security Amendments of 1983 (P.L. 98-21) established a new method of hospital payment by the Medicare program, known as the Prospective Payment System (PPS). Effective for hospital cost reporting periods that began October 1, 1983, the Medicare program has been paying hospitals, with certain exceptions, according to predetermined rates for each of 468 Diagnosis Related Groups (DRGs), rather than on a cost basis. The prospective payment legislation and regulations,

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however, continue to provide for special treatment of direct and indirect medical education costs.

Direct medical education costs under PPS. The direct costs of medical education in hospitals are excluded by law from the Prospective Payment System and are paid for separately on the basis of reasonable costs. In its December 1982 report to Congress proposing a hospital prospective payment system for Medicare, the Department favored excluding the direct costs of approved medical education programs from the prospective rates and reimbursing them on the basis of reasonable costs. As stated in the report: "This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital. This approach will allow for continued Federal support of medical education through the Medicare program while clearly identifying that support as separate from patient care." 4/

Indirect medical education costs under PPS. P.L. 98-21 requires that additional payments be made to hospitals for the indirect costs of medical education, computed in the same manner as the adjustment for indirect medical education costs was calculated under the Medicare hospital cost limits, except that the educational adjustment factor would be doubled. The Senate Finance Committee report on the Social Security Act Amendments of 1983 indicates that the adjustment for indirect medical education costs is only a proxy to account

4/ U.S. Department of Health and Human Services. Report to Congress. Hospital Prospective Payment for Medicare. Dec. 1982, pp. 47-48.

for a number of factors which may legitimately increase costs in teaching institutions. The report also states:

This adjustment is provided in the light of doubts (explicitly acknowledged by the Secretary in his recent report to Congress on prospective payment) about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents. The latter costs are understood to include the additional tests and procedures ordered by residents as well as the extra demands placed on other staff as they participate in the education process.

The committee emphasizes its views that these indirect teaching expenses are not to be subjected to the same standards of "efficiency" implied under the DRG prospective system, but rather that they are legitimate expenses involved in the post-graduate medical education of physicians which the medicare program has historically recognized as worthy of support under the reimbursement system. 5/

As provided in Medicare regulations, the payment for indirect medical education costs equals 11.59 percent of the Federal portion of a hospital's prospective payment for every 0.1 full-time equivalent (FTE) intern or resident per bed. Regulations defined the number of FTE interns and residents to be the sum of the number of interns and residents employed by the hospital for 35 hours or more per week, plus one-half of the number of interns and residents working less than 35 hours per week. For cost reporting periods beginning on or after October 1, 1984, interns and residents are not required to be employees of the hospital in order for the hospital to qualify for the indirect medical education adjustment. Hospitals are now required to document each intern or resident providing services at the facility by name and Social Security number and the number of hours the intern or resident works at that hospital.

5/ U.S. Congress. Senate. Social Security Amendments of 1983. Report to Accompany S. 1. March 11, 1983. Washington, U.S. Govt. Print. Off., 1983. (98th Congress, 1st Session. Senate Rept. No. 98-23), p. 52.

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Other provisions for teaching hospitals under PPS. In addition to the explicit provisions in the prospective payment legislation for direct and indirect medical education costs, provisions relating to payments for atypical cases also benefit teaching hospitals. Both the Finance and the Ways and Means Committee Reports indicate that the provision of additional payments for atypical cases which have either extremely long lengths of stay or extraordinarily high costs (known as "outliers") would benefit teaching hospitals since the committees believed it reasonable to expect that such cases would occur more commonly in teaching hospitals than in other hospitals.

Cost to Medicare of Health Professions Education in Hospitals.

The Report of the 1982 Advisory Council on Social Security (December 31, 1982) states that historically, expenditures for the education and training of health professionals have represented between 4 and 6 percent of annual Medicare Health Insurance (HI) Trust Fund expenditures. The Report indicates that in 1980, the HI Trust Fund spent an estimated \$1.4 billion for the direct and indirect costs of medical education programs; for 1983, the estimate is \$1.8 billion; for 1987, \$2.8 billion is estimated.

More recent estimates from the Health Care Financing Administration indicate that Medicare expenditures for health professions education may total approximately \$3 billion in 1987, \$1.4 billion for direct costs and \$1.6 billion for indirect costs. This amount would represent anywhere from 33 percent to 75 percent of total spending for health professions education in this country, assuming that the total is somewhere between \$4 billion to \$9 billion. Medicare would thus be the single largest payer for health professions education in hospitals.

Medicaid Payments for Health Professions Education in Hospitals

Medicaid is a federally aided, State-operated and administered program of medical assistance for low-income persons. Until the passage of P.L. 97-35 (the Omnibus Budget Reconciliation Act of 1981), States were required to reimburse hospitals on a reasonable cost basis as defined by Medicare. Under reasonable cost reimbursement, the direct and indirect costs of health education programs were included by hospitals in their total reasonable costs, which were then reimbursed by the State Medicaid programs for services provided to Medicaid recipients.

P.L. 97-35 gave States considerable leeway in establishing the method and level of hospital reimbursement of their choice, within certain broad Federal requirements. Approximately half the States are still using the former reasonable cost-based method of reimbursing hospitals or a variation derived from reasonable costs as formerly defined by Medicare. Although no studies exist on Medicaid payments for health professions education costs, presumably in these States the costs to hospitals of health professions education programs are being reimbursed either as a reasonable cost or as a component of the base on which a variation of reasonable cost reimbursement is built.

Other States have established alternative Medicaid hospital reimbursement systems, including prospective payment systems which apply to all payers for hospital care in the State (Maryland, Massachusetts, New Jersey, and New York), prospective payment systems using diagnosis related groups (Michigan, Ohio, Pennsylvania, and Utah), and other types of hospital payment systems, including contracting with individual hospitals (Arizona and California). Some of these systems specify how medical education costs are to be treated. In general, it appears that direct medical education costs are either passed through and reimbursed on a reasonable cost basis or they are included in a

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per diem or per admission rate paid to the hospital. The indirect costs are generally not treated separately but are implicitly included in the total rate paid to a hospital.

Health Professions Education Under the Public Health Service Act

Medical Education--Title VII of the Public Health Service Act--Background. During the recent past, there has been a rapid and large increase in the number of physicians in the country. In 1950, there were approximately 220,000 M.D.s in the U.S., representing a ratio of 134 physicians per 100,000 population. In the mid-1960s, concern was expressed about shortages of physicians and other health professionals in the nation. Efforts were supported to create more medical schools, increase class sizes in medical schools, and ease restrictions on the influx of foreign medical graduates into the country. Consequently, by 1975, the number of M.D.s in the country had increased to 393,742, for a physician ratio of 179 per 100,000 population. This number further increased, as reflected in American Medical Association (AMA) data, to 501,958 physicians in 1982, resulting in a physician-to-population ratio of 213 per 100,000.

In the 1960s and through 1970, a number of reports attested to the seriousness and scope of health personnel shortages. As late as 1970, the Carnegie Commission on Higher Education stated in a report: "The most serious shortages of professional personnel in any major occupation group in the United States are in health services." Among other things, the Commission recommended a 50 percent increase in first-year enrollments at medical schools to help eliminate a shortage of some 50,000 physicians.

In order to alleviate shortages, Congress established in 1963 in title VII of the Public Health Service Act programs of direct Federal support for health professions education. Direct Federal support became available for programs designed to increase enrollments and graduates of health professions schools. These programs were significantly expanded in several ways during the next decade. First, Congress expanded the number of programs and schools eligible for support. During this period, there were established construction grant programs; formula grant programs based on the number of students enrolled (these would later be called capitation grants); and a broad range of special project grant programs to encourage schools to undertake certain activities such as primary care training, curriculum development, and programs for disadvantaged students. At first, schools of medicine, osteopathy, and dentistry were the only schools eligible for this assistance. Later, as Congress revised and extended title VII programs, eligibility was expanded to include schools of veterinary medicine, optometry, podiatry, pharmacy, allied health, public health, and graduate programs in health administration.

There were also various student assistance programs enacted: scholarship programs and loan programs were established, as well as the National Health Service Corps scholarship program. Under this latter program, students who receive scholarship assistance are then obligated to practice in a health manpower shortage area.

Congress also, during the period 1963-73, significantly expanded the level of Federal funding for these various programs. For title VII programs, an authorization level of \$30.1 million in FY 1964 grew to an authorization level of \$1.1 billion and appropriations of \$483 million 10 years later in FY 1974.

When in 1974 the Congress began to consider revision and extension of health manpower training programs, the need to increase the aggregate supply of

health personnel no longer commanded the attention and concern it had in prior years. This was, in part, the result of an awareness that Federal support had provided substantial increases in enrollments at health professions schools. For example, first-year enrollments at medical schools increased from 8,772 in 1963-64 to 14,159 in 1973-74. Today, that number is over 16,000.

In addition, in 1974 there were the very first suggestions that the aggregate supply of health professionals would be sufficient in the near future. During hearings before the Congress in 1974, the Assistant Secretary for Health of the Department of Health, Education, and Welfare estimated that by 1980, the nation's supply of physicians would likely be adequate to meet projected requirements for physician manpower.

Instead of supply considerations, observers pointed to problems associated with the specialty and geographic maldistribution of health professionals. The nation still lacked health personnel in many rural and inner-city areas. In addition, there were thought to be too many surgeons, neurologists, radiologists, and other specialists, and not enough primary care physicians. For the first time, Congress also perceived that health professionals could assume more of the costs of their education, since their education provided them with potentially high-paying careers.

Thus, when Congress concluded consideration of the extension of title VII programs in 1976, it had begun the process of refocusing institutional assistance on special projects which would encourage health care personnel to practice in medically underserved areas, which would increase the number of primary care practitioners, and which would support other national objectives. In addition, beginning in 1976, Congress also limited financial assistance for students. For example, health professions scholarships were phased out and replaced with a more limited scholarship program for first-year students with exceptional

financial need. Revisions in 1976 also included limiting additional Federal support for the Health Professions Student Loan Program, with its government-subsidized interest rates. To supplement this program, Congress established a new Health Education Assistance Loan program, under which health professions students secure loans at prevailing market interest rates from private lenders, and these loans are guaranteed by the Federal government.

In 1980, as Congress began again to consider revision of expiring title VII programs, the Department of Health and Human Services-chartered Graduate Medical Education National Advisory Committee (GMENAC) issued its findings on the supply and requirements for physicians in the 1990s. GMENAC estimated that by 1990, there would be a surplus of 70,000 physicians in the country, and by the year 2000, this surplus would increase to 145,000.

When Congress concluded revision and extension of title VII health professions programs in 1981, it extended the authorities through FY 1984. With findings such as GMENAC's, Congress continued to focus title VII support on special training programs which attempt to address problems of health personnel geographic and specialty maldistribution, while ending support for authorities designed to increase graduates from schools where supply was expected to be adequate. At this time, Congress repealed the authority of capitation grants for all health professions schools, except for schools of public health. As noted earlier, capitation grants were established to encourage health professions schools to increase enrollment.

As the result of changes in the objectives for Federal support for health professions education, funding for title VII programs began declining in 1974. In FY 1981, funding for title VII programs amounted to \$176 million and has fallen to \$143 million in FY 1985.

Current Funding for Title VII Programs. Since its first authorization 22 years ago, title VII support has shifted from its original emphasis on increasing, in the aggregate, the nation's supply of health manpower toward directing available support to programs which are intended to address specific problems, such as the geographic and specialty maldistribution of health personnel. Today title VII funds, among other things, a number of special purpose projects, including primary care training programs; programs to provide training opportunities for students in underserved areas that are geographically removed from the main site of a health professions school (the Area Health Education Center program); a variety of curriculum development projects, including geriatric training projects; public health and health administration training; and programs to identify, recruit, and enroll minority and economically disadvantaged students wishing to pursue health careers.

One of the major areas of title VII support in recent years has been primary care training, with assistance provided for (1) the establishment of family medicine departments in medical schools; (2) residency training programs in schools and hospitals for family medicine and general dentistry; and (3) residency training programs in schools and hospitals for general internal medicine and pediatrics. Of the \$143 million appropriated for title VII programs in FY 1985, \$62 million, or 43 percent, was provided for these three programs. According to the Bureau of Health Professions in the Department of Health and Human Services, a breakdown of grants made in FY 1984 to schools and hospitals under the latter two of these programs shows that, for family medicine residency training, hospitals received \$9.4 million (average award \$133,372) and schools (medical and osteopathic) received \$10.3 million (average award \$(117,571)). For general internal medicine and pediatrics training in FY 1984, hospitals received \$2.7 million (average award \$176,733) and schools (medical and osteopathic) received \$11.9 million (average award \$201,136).

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Congress has funded primary care programs in order to encourage training opportunities in such fields as family medicine, internal medicine, and pediatrics. It has been noted that, compared with other specialty training programs, primary care programs receive less revenue from patient care services and research grants and loans and thus have greater difficulty in financing their costs. Approximately 39 percent of professionally active M.D.s are in the primary care specialties of family practice, internal medicine, and pediatrics. In 1982, the ratio of primary care physicians per 100,000 population stood at 74, compared with 117 per 100,000 population for all other medical and surgical specialties. Since 1970, the ratio of primary care physicians per 100,000 population has increased from 56 to 74 in 1982, or by 32 percent. For all other medical and surgical specialties, this ratio has increased from 92 to 117 per 100,000, or by 27 percent.

Congress has provided support for a number of programs which are intended to address problems associated with the geographic maldistribution of health professionals. These programs, such as Area Health Education Centers (AHECs) and primary care training programs (including physician assistants training programs), are intended to provide incentives for health professions schools to establish and operate training programs which might ultimately increase the number of health personnel practicing in medically underserved areas. The AHEC program, in part, establishes training opportunities for students in underserved areas that are geographically removed from the main site of the health professions school. In addition, studies have indicated that primary care specialists, especially general family practitioners, tend to establish their practices in medically underserved areas more often than other specialists. Thus, increasing the nation's supply of primary care physicians is one way of improving access to health care in previously unserved or underserved areas.

Various studies have been conducted which focus on the dynamics of the geographic distribution of health professionals. Three recent Rand Corporation studies have found that physicians were increasingly locating in less-densely populated areas, thereby indicating that market forces were alleviating problems in the geographic distribution of physicians.

However, other studies have found that counties with the lowest population and smallest numbers of physicians relative to population have been showing relatively little improvement in physician density. Such areas will continue to be economically unattractive for physicians, especially when reimbursement practices and the ability of physicians to determine the quantity of medical services provided to consumers support new physicians in well-served areas despite shortages elsewhere.

Nurse Training - Title VIII of the Public Health Service Act. Nurse training programs authorized under title VIII of the Public Health Service Act have provided Federal support for nursing schools and students since 1964. Congress consolidated and expanded programs of support for nurse education in title VIII in response to perceived shortages of professional nurses in the country. When originally enacted, title VIII provided Federal support which was intended principally to increase the aggregate supply of registered nurses in the country. It did so by encouraging nursing schools to increase their enrollments and graduates. In 1964 there were 550,000 registered nurses in the country; today there are approximately 1.6 million.

As supply increased, Federal support for title VIII has been reduced. In 1980, \$100.3 million was appropriated for title VIII programs. In 1985, \$50.3 million was appropriated. In addition, available support has shifted its emphasis from increasing the aggregate supply to targeting support on special education

programs which, among other things, train nurses to receive advanced degrees and for specific roles in the nursing profession.

A 1983 Institute of Medicine study found that, while in the aggregate there is not a significant national shortage of generalist registered nurses, shortages do occur unevenly throughout the nation in different geographic areas, in different health care settings (especially those that serve the economically disadvantaged), within institutions, and in specialty nursing.

Today, title VIII supports a special projects program which has among its purposes (1) improving the supply and distribution of nurses in geographic areas, in the various specialties of nursing, and in health care institutions; (2) recruiting and retaining minorities and economically disadvantaged individuals in schools of nursing; and (3) strengthening curriculum in areas such as geriatric and long-term care, health promotion, and disease prevention.

It also provides support for advanced nurse training programs which train nurses to become teachers or nurse specialists, or to serve in administrative or supervisory capacities. Observers have noted that since the establishment of title VIII, the demand for nurses with advanced degrees has continued to be greater than the ability of schools to prepare nurses of advanced levels to work as teachers, clinical specialists, administrators, and supervisors.

Title VIII also provides support for the training of nurse practitioners. Nurse practitioners receive advanced training to provide primary care services without the immediate supervision of a physician and often do so in medically underserved areas. Studies have indicated that nurse practitioners provide cost-effective care and increase the productivity of medical practices.

Payments by Private Payers for Health Professions Education

Since teaching hospitals have historically included the costs of health professions education in their total costs and their charges for patient care, the private payers for hospital services (including Blue Cross, commercial health insurers, prepaid health plans, and private paying patients) have traditionally financed such activities through the payments they make for patient care.

The Blue Cross and Blue Shield Association's 1978 Policy Statement on Payment to Health Care Institutions states that ". . . the cost of community services, such as research and education, should be borne primarily by the community with participation by purchasers occurring only after negotiation." Since medical education benefits society as a whole, the costs associated with medical education are considered the responsibility of the community. The Blue Cross plans generally are expected to obtain medical services for their subscribers at the best possible price. Additional costs above those required to pay for necessary and reasonable medical services are to be paid only after negotiation with the parties involved. However, historically, Blue Cross plans have paid for health professions education costs in the context of paying hospitals their costs or charges for patient care services.

The higher cost of care at teaching hospitals compared to non-teaching hospitals puts them at a disadvantage as various private payers begin to make changes in their payment methods in order to control costs. Such payment changes include paying a prospectively-established fixed rate for patient care, and negotiating contracts with hospitals offering a lower price than their competitors (i.e., a preferred provider organization, or PPO). The higher costs of teaching hospitals may mean that under fixed-price payment systems they will not be paid as large a percentage of their costs as will lower-cost non-teaching hospitals. Or it may mean that under negotiated payment schemes, teaching hospitals will not be able to compete with lower-cost non-teaching hospitals for contracts.

ISSUES

A broad range of important issues have been raised about the effects which current Medicare and Medicaid payment policies for health professions education have on patient care, on the supply and distribution of physicians and other health professionals, on the institutions providing such education, and on the costs of the programs. Similar questions need to be addressed in considering any changes in current Medicare and Medicaid policies. Some of these issues are identified and described below.

Should Medicare and Medicaid Continue to Pay for Medical Education Costs?

Some people question whether the Medicare and Medicaid programs, which were designed to pay for medical services to Medicare and Medicaid beneficiaries, should continue to underwrite the cost of medical education through their payments to hospitals. For example, in view of its perception of a financial crisis facing the Medicare program, the 1982 Advisory Council on Social Security recommended that Medicare's support for medical training be withdrawn as other sources of support are identified. Others have argued that Medicare's Hospital Insurance Trust Fund is an inappropriate source of medical education subsidy because those who benefit (primarily doctors) will generally earn incomes much higher than the employees who pay the Medicare payroll tax. Still others question whether Medicare should continue to make money available for medical education when there appears to be an adequate supply of physicians and other health care professionals except in a few areas of targeted Federal

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support, such as primary care. Finally, some critics have noted that financial support for medical education cannot be efficiently targeted as long as it remains embedded in payments for patient care.

Those who favor continuing Medicare's support for medical education fear that if Medicare were to limit or completely withdraw such support, both the training of health professionals and the provision of patient care in hospitals would suffer. These problems could be intensified if other third-party payers were to follow Medicare's lead in eliminating support for medical education. Another problem is whether other Federal, State, local, or private sources of support for medical education could be found to replace Medicare's payments if they were withdrawn. Also, if Medicare were to eliminate payments for medical education, some argue that additional Medicare dollars might be required to pay for physicians' services needed to replace the care currently provided by interns and residents.

What Are the Incentive Effects of Current Policies, and Should
Current Policies be Changed to Produce Different Effects?

Supply and Distribution Issues

As discussed above, title VII of the Public Health Act has authorized funding for primary care programs in order to provide additional training opportunities in such fields as family medicine, internal medicine, and pediatrics. Observers have noted that a hospital's main consideration in deciding what types and number of residency training programs to conduct is the hospital's patient care service requirements. Observers have also noted that, compared with other specialty training programs, primary care programs receive less revenue from patient care services and research grants and thus have greater difficulty in

financing their costs. By providing support for title VII primary care training programs, Congress has sought to increase the supply of primary care physicians relative to other medical and surgical specialties. In so doing, it has also sought to address the problem of the geographic maldistribution of physicians in the country. Studies have indicated that primary care physicians, especially family practitioners, are more likely to establish their practices in medically underserved areas than other specialists.

The nature of Federal assistance provided under title VII can be described as limited in amount and focused directly on specific training goals. By contrast, Medicare's direct support for health professions education is open-ended, cost-based, and furnished without explicit regard for its overall effect on national health professions objectives regarding the supply, specialty, or geographical distribution of health professionals. Medicare simply pays its share of the costs incurred for whatever the teaching hospital decides to do. Given the concerns and observations noted above, questions have been raised as to whether Medicare and Medicaid support for graduate medical education has the effect of encouraging subspecialty training over training in primary care and is in conflict with the goals of the title VII programs. Questions have also been raised whether an upper limit should be placed on the total amount that Medicare will spend for the costs of medical education. Additional questions have been raised whether Medicare payments should be structured so as to provide incentives for hospitals and residents to choose programs more in keeping with national health professions goals regarding the aggregate supply and the distribution of health professionals.

Some people have suggested, for example, that Medicare support for residency programs be limited, either to the first 3 years of training or to the period of training necessary to become board certified (typically 3 to 5

years), as a way of both encouraging primary care training and reducing Medicare's level of support. Others have suggested weighting the amount of support favorably towards primary care residencies or supporting only primary care residencies.

The issue of foreign medical graduates has also been raised, as it pertains to the total number, cost, and distribution of residencies. Should limits be placed on Federal funding for the graduate medical education of FMGs? Should there be a differentiation between U.S. citizens who attend medical schools in other countries and citizens of other countries who seek to obtain their graduate training in this country? With respect to non-U.S. citizens, should there be a distinction between those who intend to return to their home country after completing their residency program and those who plan to stay in this country? What affect will policies based on such distinctions have on patient care, on the supply and distribution of physicians, and on teaching hospitals?

In discussing all of these issues regarding the number and distribution of residency programs, observers have noted that there is currently no governing mechanism to make sure that the myriad of decisions by individual hospitals and medical students will, in the aggregate, be consistent with national health professions goals and objectives. If it is agreed that Medicare and Medicaid policies should be revised to promote such goals and objectives, how can this be done? How and by whom will such policies be implemented?

Locus of Medical Education Training

Most of the graduate medical education in this country is being conducted in the inpatient hospital setting. However, a trend presently exists to provide patient care in a less costly ambulatory care setting. If this

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trend continues, more medical education than at present may need to be conducted in an ambulatory care setting. More frequent use of the ambulatory care setting may promote both the health professions goal of training more primary care physicians and the health policy goal of encouraging ambulatory care over inpatient care. Under these circumstances, some suggest that a certain amount of payments for medical education should be made to health maintenance organizations and other ambulatory care settings instead of to hospitals.

The Indirect Teaching Adjustment

Under the Medicare PPS system, payments for the indirect costs of medical education activities are based on an adjustment factor which is twice as large as the previously estimated amount required to cover the implicit costs of medical education. As a result, some observers argue that residents and residency programs now generate more income for the hospital than they cost. In addition, the extra payment for the indirect costs of medical education is the same for each additional resident regardless of which specialty or year of residency is involved. Since the resource demands made by residents vary with the area of clinical specialization (e.g., surgery, pediatrics, pathology, etc.) and the experience of the resident (year of training), some residency programs are believed to be much more profitable than others. Thus, some observers argue that current Medicare policy creates incentives for hospitals to provide more medical education (i.e., train more physicians) and to train a different mix of physician specialties than would be consistent with societal needs (e.g., too many general surgeons and not enough internists).

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As discussed above, the indirect teaching adjustment is also intended to serve as a proxy for several other factors which are typically associated with teaching hospitals but may also be found in non-teaching hospitals. These include case mix, severity of illness, uncompensated care, and clinical research. Should the Medicare program make additional payments for the higher costs of teaching hospitals, even if those costs are not necessarily related to teaching activities? If so, is the indirect teaching adjustment formula, which uses a measure of direct teaching activity (interns and residents per bed) as a proxy for indirect costs, a suitable way of paying for these costs in teaching hospitals? A goal of the Prospective Payment System is to encourage efficient hospital behavior by paying a fixed price for hospital services according to patient diagnosis. Is the Medicare program paying for inefficiencies in teaching hospitals through the indirect teaching adjustment? How can the Medicare program determine if its payments to teaching hospitals are adequate or too generous? As discussed above, there are currently few studies available which provide answers to these questions.

Several policy issues and alternatives are raised by this discussion. Can the costs attributable to medical education be separated from costs pertaining to other issues stemming from PPS? If reductions seem warranted in the indirect adjustment factor, should they be made across-the-board by reducing the factor for all hospitals, or should they be targeted on certain types of institutions or programs of a certain size? Should the adjustment formula be varied by type of residency or by the year of residency, as means of promoting national health professions goals?

The Administration's Proposed Changes to Medicare's Payments
for Medical Education

The President's FY 1986 Budget proposal included several changes to Medicare's Prospective Payment System for hospitals. ^{6/} Two of the proposals affect Medicare payments to hospitals for the costs of medical education. One proposal would use regulatory authority to freeze Medicare payments to hospitals for direct medical education costs at the level received by each hospital in the hospital's cost reporting year which ended in 1984. The proposal would be effective for hospital cost reporting years beginning July 1, 1985, which is the month in which most teaching hospitals begin their cost reporting periods. The Administration indicates that the freeze is in keeping with the freezes placed on other programs in the Federal budget and will be the first step towards imposing limits on direct medical education costs. Opponents of the freeze on payments for direct medical education costs argue that there appears to be no programmatic justification for this proposal except to reduce the budget deficit.

The impact of this proposal on individual teaching hospitals depends on a hospital's ability to adjust to the frozen payment level. Some hospitals might be able to maintain their current level of support for medical education by obtaining additional money from other sources through cost-saving activities within the hospital or by shifting costs to other non-Medicare payers for hospital care. Other hospitals might have to reduce the size of their medical education programs, which has implications for the pool of trained personnel in this country. Some argue that reductions which teaching hospitals might make in medical education programs could have a differential

^{6/} The President's FY 1986 budget also proposes to end all new funding for title VII and title VIII programs.

impact on various health occupations, since reductions might be more likely to occur in training programs for nurses and allied health personnel than in programs for physicians, and more likely in residency programs for family medicine than in surgery. Another argument against the freeze proposal is that reductions which teaching hospitals might make in their residency programs could have little impact on Medicare program savings. If hospitals replace the patient care currently provided by residents with the services of physicians who are not in training, the charges for such physician services to Part B of Medicare could result in few net savings or even increased costs to the Medicare program.

A second Administration Budget proposal affecting Medicare's payments to hospitals for medical education is to seek legislative authority to reduce the indirect medical education adjustment by 50 percent. The Administration argues that there was no empirical justification for the Congress to double the factor used to calculate the indirect payment (from 5.795 percent to 11.59 percent). The Department also argues that the indirect adjustment increases the DRG payments to all teaching hospitals, whether they need the adjustment or not. Others have argued that the adjustment has resulted in windfall gains to certain teaching hospitals and provides incentives for these hospitals to increase the size of their residency programs in order to maximize payments from Medicare.

Opponents of the Administration's proposal to reduce the indirect medical education factor argue that the financial viability of teaching hospitals will be affected if they are not allowed an adjustment to the DRG payment rates sufficient to account for their higher costs. They point out that although it is called the indirect teaching adjustment, it was also intended to account

for several concerns about inadequacies in the DRG and PPS methodologies. In their view, the factor should be left as is until a method is developed to address problems such as severity of illness, case mix, clinical research, technology innovation, and uncompensated care.

The effect that reducing the doubling of the indirect adjustment would have on teaching hospitals will vary according to how dependent the hospital has been on these additional payments to subsidize its revenues. Hospitals considered to be receiving windfall payments will have their Medicare revenues reduced but might not be greatly affected by the reduction. Other teaching hospitals dependent on this adjustment to subsidize their higher cost might be severely affected. Teaching hospitals might respond in a variety of ways to a reduction in the payment for indirect costs, including instituting measures to lower costs, reducing services which are not profitable, and reducing their teaching programs.

Opponents of both proposals argue that the Administration should be more aware of the potentially adverse effects of PPS generally and the changing competitive environment, including the growth of health maintenance organizations and preferred provider organizations, and changes in payments by third-party payers.

Issues Related to Physician Reimbursement

The physician reimbursement methods adopted by various third-party payers and the costs for physician services are intertwined with issues related to health professions education in hospitals. The patient care services that residents provide in the course of their graduate medical education to some degree substitute for the services of physicians and the hospital staff. How much does a hospital save by having relatively low-cost residents providing

these services? Do the residents thus help pay for their graduate medical education? Would it be more costly to the hospital (and ultimately to the third-party payer) if someone other than a resident were performing the services? For example, if hospitals were to reduce the size of their teaching programs in response to reductions in payment under Medicare's Prospective Payment System, would costs increase under Part B of the Medicare program (the Supplemental Medical Insurance program) as physicians began billing for the services formerly provided by residents?

Another issue concerning payment for graduate medical education in hospitals is whether the whole variety of payments for physician services to hospital inpatients needs to be examined, including payments for physicians employed by the hospital, for attending physicians who bill separately for their services, for the teaching services provided by physicians, and for the services of residents in training. To what extent are third-party payers paying hospitals more than once for the same patient care service?

Another question is the extent to which the patient care fees collected by the clinical faculty of a medical school which flow into what are known as medical practice plans are used to subsidize medical education in the medical school and in the teaching hospital. What effect might reductions in payments to physicians have on this source of revenue for medical education?

Observers have also noted that other Medicare physician payment policies have encouraged training in non-primary care specialties. For most areas in the country, considerable variation exists in fees recognized by the program for certain medical services performed by physicians in general practice versus fees for similar services performed by specialists. For example, the prevailing charge for a routine follow-up office visit may be \$25 for a general practitioner and \$30 for a specialist. Concern has been expressed that these fee differentials may not be warranted and may have encouraged increased specialization.

PHYSICIAN PAYMENT UNDER MEDICARE

FRIDAY, APRIL 26, 1985

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to call, at 9:50 a.m., room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will please come to order.

The subcommittee is meeting today to hear testimony on how the Medicare Program reimburses for physician services.

We are confronted with a serious problem which demands our attention and requires that we give careful consideration to the thoughtful solutions available.

We will hear testimony this morning that the present payment rules for physician services are seriously flawed and badly in need of revision. We will also hear testimony about the temporary freeze on physician fees which we enacted last year, and the concerns people have if it is extended, as well as the concerns they have if it is allowed to lapse without protecting beneficiaries against increased out-of-pocket cost-sharing.

Neither extending the freeze, on the one hand, nor letting it lapse and reverting to the prior payment rules, on the other, seems to be entirely satisfactory. Fortunately, we will also hear testimony and look at other alternatives, so we can evaluate which of the views might be the best for us to follow.

The emphasis today will be on short-term improvements rather than long-term, basic reforms. Although there is widespread agreement about the major problems with the current system, apparently there is little consensus about what basic reforms will be most effective. I am advised that without better research and data than we now have we should be cautious about undertaking basic reforms. We will be getting major reports from Health Care Financing Administration and from the Office of Technology Assessment later this year and we will examine the various reform options in-depth at a later date.

Bearing in mind that basic reform is our eventual goal, we should now be searching for ways to improve the current payment rules and prepare a better foundation for eventual reform.

We should also bear in mind that changing the payments for physician services will not, alone, resolve all the issues and problems posed in making sure that these services are appropriate, ac-

cessible, efficiently delivered and of highest quality. Other policies, involving health manpower, technology assessment, quality assurance and utilization review, are also important and must be considered.

It is clear, however, that improving the payment system is a cornerstone in any strategy designed to meet these objectives. I believe today's hearing will provide us with a good basis for beginning that task. In addition to several distinguished witnesses, I understand we expect to receive written statements from several groups that are interested in this topic. Without objection, they will be placed in the record.

I would like to call on any members of the subcommittee who wish to make opening statements.

Mr. NIELSON. Thank you, Mr. Chairman.

Just a very brief statement.

I have been involved in this issue for some time and I have dealt with—I had a meeting with the American Emergency Practitioners in San Diego, and this is one of the major concerns they have, as to whether or not they can afford to stay on this physician fee system. They are willing to share the pain with other segments of the economy, but they also feel they have done their share and have done their part and it has not worked well. Many are advising their own sons not to go into medicine because they feel it is not being handled properly and fairly.

So it is a concern to the medical fraternity. I am concerned that we have enough physicians in the right places and the right facilities and the right specialties, I should say, and I think we need to look carefully at what we do.

For one thing, we don't freeze the components of the medical fees. The malpractice fees have gone up by 80 percent in some areas, sometimes more than that, and yet the physician fees have not changed. So unless we are willing to freeze some of the major insurance and other components involved in the physician fees it may be unfair to freeze, like putting the lid on a boiling kettle.

You may have an explosion. You may lose the very resources you have. You may have a larger cost in the long run. That is one of the things I would like to look at carefully.

I think we have to be extremely careful, HCFA has probably the toughest emission of any part of the Congress, I don't envy you your tremendous task, I know you are doing the best you can in this area, but please look at all the components of the medical dollar, not just the fee the physicians charge.

Thank you.

Mr. WAXMAN. Thank you very much, Mr. Nielson.

Now, someone who will support the Reagan administration position, Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman, and I appreciate your leadership in this area.

It seems to me that our challenge here is just enormous. We are trying to assure top quality care at affordable prices and in order to do that we will have to show that good quality care and reasonable costs can be two sides of the same coin.

I think that is going to be an enormously tough undertaking, but an important one and I am glad we are having this hearing.

It seems to me that today's charge-based system rewards the inefficient and penalizes the efficient. I think that is very central to trying to develop solutions to the problem.

The freeze idea, I think, is just an oversimplified answer. First, it would freeze the current inequities into the system and second, it will undermine the incentives for physicians to come forward and take special steps to hold down costs for older people.

I think the key for the future will involve two things, Mr. Chairman. First, I think we have to get away from the idea that we are going to buy medical care in this country a la carte. I think we have to look at packages like health maintenance organizations and others, that get away from this a la carte focus.

Second, I think the future will bring more at-risk programs, where doctors and other providers agree up front to take patients under a per capital kind of an arrangement under an at-risk arrangement, there will be incentives to hold down the costs while keeping quality high.

I think this is clearly a very, very difficult subject, Mr. Chairman, and I appreciate your leadership and thank you for holding this hearing.

Mr. WAXMAN. Thank you very much, Mr. Wyden.

We are pleased to welcome a our first witness, Dr. Carolyne Davis, to talk to us about the subject of experiences we have had, what we have learned from them and what our policies should be in the future, both in the short-term and long-term.

Your prepared statement will be made a part of the record in full, and we would like to have you summarize that statement.

STATEMENT OF CAROLYNE K. DAVIS, Ph.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY CAROL A. KELLY, ACTING ASSOCIATE ADMINISTRATOR FOR POLICY, AND HENRY DESMARAIS, DIRECTOR OF THE BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE

Dr. DAVIS. Thank you, Mr. Chairman.

I am very pleased to be here today to discuss both the changes in Medicare physician reimbursement mandated by the Deficit Reduction Act, and also the administration's proposals for fiscal year 1986.

Let me first introduce the two people from my staff accompanying me today. On my left is Carol Kelly, the Acting Associate Administrator for Policy; and on my right is Dr. Henry Desmarais, Director of the Bureau of Eligibility, Reimbursement, and Coverage.

As a result of the DEFRA physicians payment provisions and also the impact of the hospital prospective payment system, we have been successful in both reducing the rate of growth in physician spending for Medicare as well as increasing the Medicare financial protection to the beneficiaries.

Now, the administration is seeking a continuation of the freeze, both to maintain the restraint in the reimbursement until we have a longer term reform, and also to help reduce the Federal deficit. I think that both reasons are equally important.

We don't frankly expect that if we have an extension of the freeze there is going to be a significant negative impact on either access or quality of care.

To look a little at the background, I think it is important to recognize that over the 10-year period that ended in fiscal year 1983, Medicare spending for physicians services increased at an annual rate of close to 20 percent.

Then in fiscal year 1984, there was a significant deceleration in the rate of growth for the payment of services to nearly half that of the previous 10 years. That type of deceleration is carrying over into the current fiscal year.

The deceleration in fiscal year 1984 was due to a number of factors. As I mentioned earlier, the impact of the prospective system on the physicians services provided to the hospital in-patients is one; the others include the reduction in the rate of increase in medical inflation and the other changes that were mandated as a result of the Social Security Amendments of 1983 and also the Deficit Reduction Act.

It is clear that the freeze on physician fees also played a role in this and it is helping to maintain that trend. I think it is significant that over the past 4 years in terms of looking at the Medicare Program that until the changes enacted by DEFRA, the legislative changes had a relatively small direct impact on physicians. But as a result of DEFRA, there were several changes made.

The participating physician program was initiated, the customary and prevailing charges were frozen for a 15-month period, the actual charges of nonparticipating physicians were frozen and physicians were no longer to bill for laboratory services they didn't directly provide.

Two activities I would like to highlight are the participating physician program and the freeze on the nonparticipating doctors.

Looking at the participating physicians program prior to DEFRA, physicians could accept assignment on a claim-by-claim basis. For the first time, DEFRA provided a voluntary participation program and yet it still retained the option for claim-by-claim assignment for nonparticipating physicians.

A doctor can be a participating physician if he agrees to accept assignment for all claims in the 1-year period. The participating physician program is a rather significant change for the beneficiaries because they now know the services provided by participating physicians will always be accepted on assignment.

The beneficiaries are concerned about their out-of-pocket expenses and can consult the directories that contain names and addresses of participating physicians in their area.

The Deficit Reduction Act was enacted in July and the first participation period began less than 3 months later.

It was during that period of time that the carriers sent letters to all of the physicians to inform them of the provisions in the new statute and to describe the incentives for participation.

During October, we sent brochures to all 30 million beneficiaries that explained the provisions of the participating physician program and directed them to contact their local carriers for additional information.

The carriers enhanced their toll-free telephone capacity in order to handle the inquiries and by the end of November, we had sent copies of the participating physician directories to all the Social Security district offices, the State and area agencies on aging and senior citizen organizations. They were also sent to the congressional district offices.

In fact we distributed around 9,600. In addition, the directories were available for purchase through our carriers for a minimal price, and we have actually sold about 17,400 of them at \$2 a piece. Perhaps you might be interested in looking at what those participating physician lists look like. I am asking my staff if they would share with you those documents.

We did have those sent out and they are being heavily used, we are told.

In your package you will also find a little emblem which we gave to each one of the physicians when they signed up for participation.

In the first year of the program, the percent of physicians who always accept assignment grew from an estimated 20 percent to 30 percent. More importantly, the overall dollar assignment rate for the first quarter of the program was 63.9 percent, and that represents a 14.1-percent increase over the same quarter in the previous year and an 8-percent increase over just the previous quarter.

In the most recent quarter the assignment rate again increased. The assignment rate claim by claim is now 66.9 percent.

Thus, the participating physician program and the other changes enacted by DEFRA have increased the financial protection that the Medicare Program is able to afford its beneficiaries. I believe the members of this committee should be commended for their role in this particular process. I know it was a very active role.

As a result of the Deficit Reduction Act the actual charges of the nonparticipating physicians were frozen to the base period of April through June 1984, and any nonparticipating physician who knowingly and willfully bills beneficiaries for their actual charges in excess of those used in the base period may face a civil money penalty and/or exclusion from the program.

To date, virtually all the nonparticipating physicians seem to be complying with the freeze. We have fewer than 3 percent of the total nonparticipating physicians who have been sent a warning letter.

In our efforts to reduce the rate of growth in physician expenditures, we believe that we need to continue the freeze extension. If we were to take no additional action to control spending in fiscal year 1986, the outlays for physician payments would grow faster than any other domestic function in the Federal Government.

The President's budget proposed no increase in the customary and prevailing charges for physicians in fiscal year 1986 for that reason.

The recent Senate-White House compromise would give participating physicians an increase in their payments for fiscal year 1986 but extend the current freeze for an additional year for all nonparticipating physicians.

That proposal will maintain the consistency with the other Medicare freeze proposals and the overall budgetary objectives.

I think it is clear that the proposed freeze does not address the overall issues of appropriate physician reimbursement reform. As you know, Congress asked us to study that particular activity and that project is very high on our priority list in the agency. We are exploring a number of options, looking both at the advisability and feasibility of paying hospital inpatient physician services on the basis of the hospital DRG group as well as looking at fee schedules and capitation types of approaches.

However, the options that we are reviewing simply couldn't be ready for congressional review and use in fiscal year 1986.

In addition to the physician reimbursement report we are also preparing a report on changes in the volume and mix of physician services that were requested in the Deficit Reduction Act, tracking those that might have resulted from the physician fee freeze.

We expect to forward our findings on that study probably at the same time as the physician DRG report.

I can assure you that we have indeed been committed to finding a satisfactory resolution to containing spending while continuing to assure access to quality of care for the beneficiaries.

I look forward to the continuing dialog with this committee as we move forward to pursue reform in this area.

[The prepared statement of Dr. Davis follows:]

STATEMENT OF
CAROLYNE K. DAVIS, Ph.D.
ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION

I AM PLEASED TO BE HERE TODAY TO DISCUSS BOTH THE CHANGES TO MEDICARE PHYSICIAN REIMBURSEMENT MANDATED BY THE DEFICIT REDUCTION ACT OF 1984 (DEFRA) AND THE ADMINISTRATION'S PROPOSAL FOR FY 1986. ACCOMPANYING ME TODAY ARE CAROL A. KELLY, ACTING ASSOCIATE ADMINISTRATOR FOR POLICY AND DR. HENRY DESMARAIS, DIRECTOR OF THE BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE.

AS A RESULT OF DEFRA'S SEVERAL PHYSICIAN PAYMENT REFORMS AND THE IMPACT OF THE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (PPS), WE HAVE BEEN SUCCESSFUL IN BOTH REDUCING THE RATE OF GROWTH IN MEDICARE PHYSICIAN SPENDING AND IN INCREASING MEDICARE'S FINANCIAL PROTECTION TO BENEFICIARIES.

THE ADMINISTRATION IS SEEKING A CONTINUATION OF THE DEFRA FREEZE ON PHYSICIAN PAYMENTS BOTH TO MAINTAIN RESTRAINT ON MEDICARE REIMBURSEMENT UNTIL LONGER TERM MEDICARE REFORMS ARE READY TO BE PUT IN PLACE, AND TO HELP REDUCE THE FEDERAL DEFICIT. WE DO NOT EXPECT THAT THIS EXTENSION WILL HAVE ANY NEGATIVE IMPACT ON ACCESS TO OR QUALITY OF CARE.

BACKGROUND

OVER THE TEN YEAR PERIOD ENDING IN FY 1983, MEDICARE SPENDING FOR PHYSICIANS' SERVICES INCREASED AT AN ANNUAL RATE OF GROWTH OF CLOSE TO 20 PERCENT. DURING THE SAME PERIOD, THE FEDERAL BUDGET AND THE

GROSS NATIONAL PRODUCT GREW AT ANNUAL RATES OF 12.3 PERCENT AND 9.6 PERCENT, RESPECTIVELY. IN EACH OF THE LAST FIVE YEARS OF THIS PERIOD, SPENDING FOR PHYSICIANS' SERVICES OUTPACED MEDICARE SPENDING FOR INPATIENT HOSPITAL SERVICES.

IN FY 1984, THERE WAS A SIGNIFICANT DECELERATION IN THE RATE OF GROWTH IN MEDICARE PAYMENTS FOR PHYSICIANS' SERVICES. TO DATE, THIS DECELERATION IS CARRYING OVER INTO THE CURRENT FISCAL YEAR. THE ANNUAL RATE OF INCREASE IN FY 1984 WAS NEARLY HALF THAT OF THE PREVIOUS TEN YEARS.

THIS FY 1984 DECELERATION WAS DUE TO A NUMBER OF FACTORS:

- 0 THE DROP IN ADMISSIONS FOLLOWING THE IMPLEMENTATION OF PPS, BESIDES REDUCING HOSPITAL EXPENDITURES, ALSO REDUCED EXPENDITURES FOR PHYSICIANS' SERVICES PROVIDED TO HOSPITAL INPATIENTS.
- 0 SIMILARLY, THE REDUCTION IN HOSPITAL LENGTH OF STAY ALSO PRODUCED PHYSICIANS' SERVICES SAVINGS.
- 0 THE REDUCTION IN THE RATE OF INCREASE IN MEDICAL INFLATION REDUCED THE PRICE COMPONENT OF FEE INCREASES. THE AMA VOLUNTARY FREEZE MAY HAVE BEEN A CONTRIBUTING FACTOR TO THIS CHANGE.
- 0 ALSO, THERE MAY HAVE BEEN SOME SHIFT IN SERVICES FROM THE PHYSICIAN CATEGORY TO INDEPENDENT LAB AND HOSPITAL INPATIENT AS A

RESULT OF CHANGES MANDATED BY THE SOCIAL SECURITY AMENDMENTS OF 1983 AND BY DEFRA.

THE FREEZE ON PHYSICIANS' FEES MANDATED BY DEFRA ALSO PLAYED A ROLE IN THIS DECELERATION AND IS HELPING TO MAINTAIN THE TREND.

DEFICIT REDUCTION ACT OF 1984

OVER THE PAST FOUR YEARS, SIGNIFICANT CHANGES TO THE MEDICARE PROGRAM HAVE BEEN ENACTED IN THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981, THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA), THE SOCIAL SECURITY AMENDMENTS OF 1983 AND DEFRA. A MAJOR FOCUS OF TEFRA AND THE SOCIAL SECURITY AMENDMENTS OF 1983 WAS CONTROLLING THE GROWTH OF MEDICARE SPENDING FOR HOSPITAL SERVICES. UNTIL DEFRA, THESE LEGISLATIVE CHANGES ENACTED BY CONGRESS HAD A RELATIVELY SMALL DIRECT IMPACT ON ALL PHYSICIANS.

AS A RESULT OF DEFRA, THE FOLLOWING CHANGES WERE MADE TO PHYSICIAN REIMBURSEMENT UNDER MEDICARE:

- O A PARTICIPATING PHYSICIAN PROGRAM WAS INITIATED.
- O THE CUSTOMARY AND PREVAILING CHARGES OF PHYSICIANS WERE FROZEN FOR A 15 MONTH PERIOD.

- 0 THE ACTUAL CHARGES OF NON-PARTICIPATING PHYSICIANS WERE ALSO FROZEN.
- 0 PHYSICIANS WERE NO LONGER ALLOWED TO BILL FOR LABORATORY SERVICES THAT THEY DID NOT DIRECTLY PROVIDE.

I WOULD LIKE TO SPECIFICALLY ADDRESS THE PARTICIPATING PHYSICIAN PROGRAM AND THE FREEZE ON THE ACTUAL CHARGES OF NON-PARTICIPATING DOCTORS.

PARTICIPATING PHYSICIAN PROGRAM

PRIOR TO DEFRA, PHYSICIANS COULD ACCEPT THE MEDICARE-DETERMINED REASONABLE CHARGE AS PAYMENT IN FULL, THAT IS ACCEPT ASSIGNMENT, ON A CLAIM-BY-CLAIM BASIS. ON AN ASSIGNED CLAIM, THE PHYSICIAN SENDS THE BILL DIRECTLY TO MEDICARE, AND THE BENEFICIARY CAN BE BILLED ONLY FOR THE APPLICABLE COST-SHARING.

ON AN UNASSIGNED CLAIM, THE PHYSICIAN IS PAID BY THE BENEFICIARY, WHO THEN SUBMITS A CLAIM TO MEDICARE. THE BENEFICIARY IS RESPONSIBLE BOTH FOR APPLICABLE COST-SHARING AND FOR ANY DIFFERENCE BETWEEN THE PHYSICIAN'S ACTUAL CHARGE AND MEDICARE'S PAYMENT.

DEFRA CREATED A VOLUNTARY MEDICARE PARTICIPATING PHYSICIAN PROGRAM WHILE RETAINING THE CLAIM-BY-CLAIM ASSIGNMENT OPTION FOR NON-

PARTICIPATING PHYSICIANS. A DOCTOR CAN BECOME A PARTICIPATING PHYSICIAN BY AGREEING TO ACCEPT ASSIGNMENT ON ALL CLAIMS FOR A ONE YEAR PERIOD.

THE PARTICIPATING PHYSICIAN PROGRAM IS A SIGNIFICANT CHANGE FOR BENEFICIARIES BECAUSE THEY NOW KNOW THAT SERVICES PROVIDED BY PARTICIPATING PHYSICIANS WILL ALWAYS BE ACCEPTED ON ASSIGNMENT. BENEFICIARIES WHO ARE CONCERNED ABOUT OUT OF POCKET EXPENSES CAN CONSULT DIRECTORIES CONTAINING THE NAMES AND ADDRESSES OF PARTICIPATING PHYSICIANS IN THEIR AREA.

DEFRA WAS ENACTED IN JULY AND THE FIRST PARTICIPATION PERIOD BEGAN LESS THAN THREE MONTHS LATER. DURING THAT PERIOD OF TIME, THE MEDICARE CARRIERS SENT LETTERS TO ALL PHYSICIANS INDICATING THE PROVISIONS OF THE NEW STATUTE AND OFFERING THE OPPORTUNITY TO PARTICIPATE.

THE LETTER DESCRIBED THE INCENTIVES FOR PHYSICIANS TO PARTICIPATE. THESE INCLUDED: EXEMPTION FROM THE FREEZE ON ACTUAL CHARGES; THE PUBLICATION OF DIRECTORIES OF PARTICIPATING PHYSICIANS BY CARRIERS; ENHANCED CARRIER CAPACITY TO RECEIVE CLAIMS ELECTRONICALLY SUBMITTED; AND DECALS AND CERTIFICATES FOR PHYSICIANS TO USE IN THEIR OFFICE INDICATING THEIR PARTICIPATION STATUS.

A KEY ASPECT OF THE IMPLEMENTATION OF THE PROGRAM WAS INFORMING MEDICARE BENEFICIARIES. DURING OCTOBER, ALL THIRTY MILLION

BENEFICIARIES WERE SENT A BROCHURE CONCERNING THE PROVISIONS OF DEFRA. THE BROCHURE DISCUSSED THE FEE FREEZE AND THE PARTICIPATING PHYSICIAN PROGRAM, DIRECTING BENEFICIARIES TO THEIR LOCAL CARRIER FOR ADDITIONAL INFORMATION. CARRIERS HAVE ENHANCED THEIR TOLL-FREE TELEPHONE-LINE CAPACITY TO HANDLE BENEFICIARY INQUIRIES. SUFFICIENT LINES HAVE BEEN INSTALLED SO THAT ENROLLEES DO NOT RECEIVE REPEATED BUSY SIGNALS AND ARE NOT PUT ON HOLD FOR LENGTHY PERIODS.

BY THE END OF NOVEMBER, COPIES OF PARTICIPATING PHYSICIAN DIRECTORIES HAD BEEN SENT TO SOCIAL SECURITY DISTRICT OFFICES, STATE AND AREA AGENCY ON AGING OFFICES AND SENIOR CITIZEN ORGANIZATIONS. THEY WERE ALSO SENT TO CONGRESSIONAL DISTRICT OFFICES. IN ADDITION, DIRECTORIES ARE AVAILABLE FOR PURCHASE THROUGH OUR CARRIERS FOR A MINIMAL PRICE.

IN THE FIRST YEAR OF THIS PROGRAM, THE PERCENT OF PHYSICIANS ALWAYS ACCEPTING ASSIGNMENT GREW FROM AN ESTIMATED 20 PERCENT TO 30 PERCENT. ALTHOUGH IT IS DIFFICULT TO SEPARATE THE IMPACT OF THE PARTICIPATING PHYSICIAN PROGRAM FROM OTHER DEFRA CHANGES, THERE WAS A DRAMATIC INCREASE IN THE DOLLAR ASSIGNMENT RATE DURING THE FIRST QUARTER OF THE PROGRAM. THE ASSIGNMENT RATE FOR THE OCTOBER-DECEMBER QUARTER WAS 63.9 PERCENT, AN INCREASE OF 14.1 PERCENT OVER THE SAME QUARTER IN THE PREVIOUS YEAR AND 8.1 PERCENT OVER JUST THE PREVIOUS QUARTER. IN THE MOST RECENT QUARTER, THE ASSIGNMENT RATE AGAIN INCREASED. THUS, THE PARTICIPATING PHYSICIAN PROGRAM AND THE OTHER CHANGES ENACTED BY DEFRA, LEADING TO A HIGHER DOLLAR ASSIGNMENT RATE, PROTECTED OUR

BENEFICIARIES. THE MEMBERS OF THIS COMMITTEE ARE TO BE COMMENDED FOR THEIR ROLE IN THAT PROCESS.

MONITORING THE FREEZE ON NON-PARTICIPATING PHYSICIANS

AS A RESULT OF DEFRA, THE ACTUAL CHARGES OF NON-PARTICIPATING PHYSICIANS WERE FROZEN TO A BASE PERIOD OF APRIL-JUNE 1984. ANY NON-PARTICIPATING PHYSICIAN WHO "KNOWINGLY AND WILLFULLY" BILLS ENROLLEES FOR ACTUAL CHARGES IN EXCESS OF THOSE USED IN THE BASE PERIOD MAY FACE A CIVIL MONEY PENALTY AND/OR EXCLUSION FROM THE PROGRAM.

IN ORDER TO IMPLEMENT THIS FREEZE OUR CARRIERS ARE MONITORING, ON A QUARTERLY BASIS, CHANGES IN THE ACTUAL CHARGES FOR THE HIGH VOLUME PROCEDURES BILLED BY EACH PHYSICIAN AND FOR ADDITIONAL PROCEDURES SELECTED AT RANDOM. WHERE THERE IS AN INDICATION THAT A PHYSICIAN IS VIOLATING THE FREEZE, THAT PHYSICIAN'S BILLINGS ARE GIVEN AN INDEPTH REVIEW BY CARRIER STAFF. IF THAT REVIEW DOES NOT UNCOVER AN EXPLANATION FOR THE INCREASE, THE CARRIER SENDS A LETTER INDICATING THAT THE PHYSICIAN MAY BE VIOLATING THE FREEZE.

THE PHYSICIAN HAS 15 DAYS TO RESPOND TO THE LETTER. IF THERE IS NO RESPONSE OR IF THE RESPONSE IS UNACCEPTABLE, INTENSIVE MONTHLY MONITORING BEGINS. THIS INTENSIVE MONITORING WILL BE MAINTAINED FOR AT LEAST TWO MONTHS IN ORDER TO ESTABLISH THAT THERE WAS A KNOWING AND WILLFUL VIOLATION OF THE STATUTE. IF THERE IS CONTINUED VIOLATION OF THE FREEZE, THE CARRIER MUST CONTACT THE PHYSICIAN IN PERSON OR BY

PHONE. AFTER THIS POINT, THE CASE IS REFERRED TO THE OFFICE OF INSPECTOR GENERAL.

TO DATE, VIRTUALLY ALL NON-PARTICIPATING PHYSICIANS HAVE BEEN COMPLYING WITH THE FREEZE. FEWER THAN THREE PERCENT HAVE BEEN SENT WARNING LETTERS.

MAINTAINING THE FREEZE

THE SENATE/WHITE HOUSE COMPROMISE FREEZES FEES FOR NON-PARTICIPATING PHYSICIANS FOR TWELVE MONTHS BEGINNING OCTOBER 1, 1985. THE COMPROMISE GIVES PARTICIPATING PHYSICIANS AN INCREASE IN THEIR PAYMENTS FOR FY 86. THE PRESIDENT'S BUDGET PROPOSES NO INCREASE IN THE PAYMENTS FOR PHYSICIANS IN FY 86.

IN THE CONTEXT OF THE ADMINISTRATION'S SUPPORT OF THE COMPROMISE WITH THE SENATE LEADERSHIP, WE WOULD NOT BE OPPOSED TO THE SENATE PROPOSALS FOR PHYSICIANS IF THE ENTIRE DEFICIT REDUCTION PACKAGE IS ACCEPTED BY THE CONGRESS.

OUR EFFORTS TO REDUCE THE RATE OF GROWTH IN PHYSICIAN EXPENDITURES NEED TO CONTINUE. IF WE WERE TO TAKE NO ADDITIONAL ACTION TO CONTROL SPENDING IN FY 1986, OUTLAYS FOR PHYSICIAN PAYMENTS WOULD GROW FASTER THAN ANY DOMESTIC FUNCTION IN THE FEDERAL BUDGET.

THE ADMINISTRATION HAS PROPOSED A ONE YEAR EXTENSION OF THE PHYSICIAN FEE FREEZE. THIS WILL MAINTAIN CONSISTENCY WITH THE OTHER MEDICARE FREEZE PROPOSALS AND OVERALL BUDGETARY OBJECTIVES. EVEN WITH AN EXTENSION OF THE FREEZE AND THE ADMINISTRATION'S OTHER FY 1985 PROPOSALS, ADDITIONAL SERVICES AND ADDITIONAL ENROLLEES WILL INCREASE MEDICARE PAYMENTS FOR PHYSICIANS' SERVICES BY 9.7 PERCENT TO \$18 BILLION.

WE BELIEVE OUR PROPOSAL IS EQUITABLE TOWARD PHYSICIANS. THE COMMITTEE IS AWARE THAT PRIOR TO DEFRA, THE MAJOR MEDICARE STATUTORY CHANGES OF THE PAST FOUR YEARS DID NOT HAVE A DIRECT SIGNIFICANT IMPACT ON ALL PHYSICIANS. IN DEFRA, THE MEDICARE SAVINGS FROM PROVISIONS AFFECTING PHYSICIANS WERE OF THE SAME ORDER OF MAGNITUDE AS SAVINGS FROM PROVISIONS AFFECTING BENEFICIARIES AND OTHER PROVIDERS.

FUTURE DIRECTIONS

IT IS CLEAR THAT THE PROPOSED FREEZE DOES NOT ADDRESS THE OVERALL ISSUE OF APPROPRIATE PHYSICIAN REIMBURSEMENT. CONGRESS HAS ASKED US TO STUDY PHYSICIAN REIMBURSEMENT REFORM. THIS PROJECT IS A HIGH PRIORITY IN HCFA AND WE ARE CURRENTLY EXPLORING A NUMBER OF OPTIONS. HOWEVER, THE NEW OPTIONS THAT WE ARE REVIEWING COULD NOT BE READY FOR POLICY LEVEL OR CONGRESSIONAL REVIEW AND FOR USE IN FY 85.

THE SOCIAL SECURITY AMENDMENTS OF 1983 REQUIRE US TO REPORT ON THE ADVISABILITY AND FEASIBILITY OF PAYING HOSPITAL INPATIENT PHYSICIAN SERVICES ON THE BASIS OF HOSPITAL DIAGNOSTIC RELATED GROUPS (DRG),

THAT REPORT IS DUE THIS JULY AND WE HAVE MADE SIGNIFICANT PROGRESS TOWARD THAT END. THIS INVOLVES MERGING THE HOSPITAL AND PHYSICIAN CLAIMS DATA BASES; STUDYING THE VARIATION IN PHYSICIAN CHARGES WITHIN EACH DRG; ASSESSING THE FEASIBILITY OF IMPLEMENTATION OPTIONS; AND ANALYZING THE EXPECTED IMPACT ON BENEFICIARIES, PHYSICIANS, HOSPITALS, AND THE BUDGET.

WE ARE ALSO CAREFULLY EXAMINING OTHER PHYSICIAN REIMBURSEMENT OPTIONS SUCH AS FEE SCHEDULES AND CAPITATION APPROACHES. I CAN ASSURE YOU THAT WE ARE AND HAVE BEEN COMMITTED TO FINDING A SATISFACTORY SOLUTION TO CONTAINING SPENDING YET ASSURING ACCESS TO QUALITY CARE FOR OUR BENEFICIARIES.

IN ADDITION TO THE PHYSICIAN DRG REPORT, WE ARE ALSO PREPARING A REPORT ON CHANGES IN THE VOLUME AND MIX OF PHYSICIAN SERVICES THAT MAY HAVE RESULTED FROM THE FEE FREEZE. ALTHOUGH THIS QUESTION IS COMPLICATED BY THE OTHER CHANGES OCCURING IN THIS AREA BESIDES THE FEE FREEZE, WE EXPECT TO BE FORWARDING OUR FINDINGS AT THE SAME TIME AS THE PHYSICIAN DRG REPORT.

I LOOK FORWARD TO A CONTINUING DIALOGUE WITH THIS COMMITTEE AS WE CONTINUE TO PURSUE PHYSICIAN REIMBURSEMENT REFORM ISSUES. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE.

Mr. WAXMAN. Thank you very much, Dr. Davis.

The administration's proposal to the Congress, as I understand it, just extends the freeze, so as to limit the amount that the Federal Government would pay to physicians under Medicare to what was paid in the previous 15-month period. There was no mention of participating physician. There was no mention of any other factors. It was simply extension of the freeze for another year. Is that correct?

Dr. DAVIS. That is correct. That was the initial proposal.

Mr. WAXMAN. The initial proposal, OK. Now, you have another proposal worked out with the Senate and let me see if I understand that proposal. It has some changes in it. It would extend the freeze, which means it would limit the amount of money the Government will pay to physicians for their fee under Medicare. But, if you were what we call participating physician, meaning you agreed to take Medicare assignments, then you would get an increase. Is that correct?

Dr. DAVIS. You would be allowed to have your charges go up as we initially indicated, yes.

Mr. WAXMAN. Now, the fee limits in effect for 15 months not only froze the Medicare payment from the Government but told physicians that their fees had to be frozen across the board when they had a Medicare patient. They couldn't turn around and ask the patient to pay more, even if they didn't take assignment.

In other words, we put price controls on doctors' fees insofar as treating Medicare patients, is that correct?

Dr. DAVIS. Yes.

Mr. WAXMAN. That wasn't the original proposal from the administration this time around. Is that part of the proposal now worked out with the Senate? In other words, are you going to extend the price controls on physician's fees, not just the controls on the amount the Government pays the physicians? Would you limit the physicians on how much they can charge the patient where they would not take assignment?

Ms. KELLY. Mr. Waxman, the administration's original proposal did include the participating physician program and the controls on the actual charges of nonparticipating physicians.

That will be in the legislative package that the administration will send up to the Hill about the next month.

As I understand it, the compromise we have reached with the Senate includes those items also.

Mr. WAXMAN. How did you originally treat those two items? I do not understand the differences between what you originally proposed and what you agreed to with the Senate.

It may not be relevant because you may now stand behind the agreement with the Senate. The only reason I press for the distinctions is because your prepared statement has a very carefully couched phrase that made me a little concerned. It says, in the context of the administration's support of the compromise with the Senate leadership, "we would not be opposed to the Senate proposals for physicians if the entire deficit reduction package is accepted by the Congress."

That means to me that you are not solidly behind that compromise with the Senate unless everything in that package goes through exactly the way it was agreed upon.

Dr. DAVIS. That is correct.

Mr. WAXMAN. That means we could be back to the original administration proposal and look at that as a viable option for your recommendations to us; is that a correct statement?

Dr. DAVIS. Yes.

Mr. WAXMAN. That is why I wanted to understand what you originally proposed and what changes you were willing to make only if the whole Republican Senate and administration package held together.

Originally you proposed participating physician provisions. Would that participating physician receive an increase?

Ms. KELLY. In the Administration's original provision, no. The program itself of signing up physicians for directories and making these available to beneficiaries under current law would have a continuing life, but we would not have updated the charges of participating physicians, if I can make that distinction.

Mr. WAXMAN. So a physician can choose to be a participant in the Medicare Program in the sense he is or she is willing to take assignment from the Government of the fee that Medicare would pay as a total payment for his bill but that wouldn't give him an increase over and above the 15-month freeze, it would only allow his name to be in the directory as a participating physician.

Ms. KELLY. Yes.

Mr. WAXMAN. How about the nonparticipating? If he wanted to increase the charges to the patients, would there be a restriction on his ability to do so?

Ms. KELLY. Yes, sir, both bills freeze the actual charges on nonparticipating physicians.

Mr. WAXMAN. So there would be a continuation of price controls on physicians, not just what the Government pays the physician?

Ms. KELLY. Yes.

Dr. DESMARAIS. The distinction has to be made that if you are a participating physician you are allowed to bill higher charges and those higher charges would be used in some subsequent period to calculate your new Medicare payment amounts. That is the distinction for the participating physician.

Mr. WAXMAN. It is an interesting concept because of the 15-month freeze with price controls. In adopting that, we told physicians "If you are good guys and take assignment, we will let you upgrade your fee even though you won't get paid that upgraded amount, and then after 15 months this freeze is going to go off and you, because you participated and were a good guy, will get more money because the increased Medicare fee would reflect the fact that you were allowed to increase your charges."

Now after that promise was made, we are going to have another year tacked on where he will have the same promise. So eventually he will be told that promise will be kept.

How credible a promise is that when we told physicians if they participated we would give them an extra benefit and turn around after 15 months and extend that freeze on them? How credible do you think that will be, Dr. Davis?

Dr. DAVIS. As I indicated earlier, we view it as simply a delay of 1 year. They would still be able to have their charges increased but simply recognized at a later point. However, we would like to point

out that when there were discussions held in the Senate and this was brought up, there was agreement that the participating physicians would be allowed to have their charges increased.

It is a part of the whole budget package, in any case, where there are various agreements worked out. If that package falls through, we would have to sit down and see what we would be willing to work out again.

Mr. WAXMAN. Now, we are in the middle of this 15-month, very strange way of handling Medicare payments to physicians. It is the only group in the country we told if you participate in the Medicare Program at all—not even talking about assignment—you cannot raise your fees. This is the only group we put price controls on.

As my colleague mentioned, many of these physicians have had increases in costs to them for doing business. Medical malpractice insurance is one area that obviously went up, but just the cost of doing business went up.

The freeze we have in effect is based on the fee, not for the 1984 fiscal year, but for previous years. Don't we always limit the allowable fee, based on the previous period of time, not on the time in which we are acting.

Dr. DAVIS. That is correct.

Mr. WAXMAN. Isn't it the case we are talking about what is, in effect, a freeze on what physicians charged in 1982?

Dr. DAVIS. That is correct. I think it is important, however, to recall that in 1983 the average net income for physicians was \$106,000. So I think you begin to—

Mr. WAXMAN. That is not an answer to my question. A lot of people have a lot of money. That is not reason for making policy decisions on how we are going to handle a program for the people who don't have a lot of money, at least many of them, who are on Medicare.

That is who we care about; right?

Dr. DAVIS. That is correct.

Mr. WAXMAN. Now, doctors are being paid at the 1982 level fee and they are frozen at that amount, and the administration would continue to freeze them at that amount, with a restriction on their ability to raise the amount they charge the patient.

Now, a lot of doctors thought that was a tough kind of provision imposed on them. But we said, you are going to have to live up to it or we are going to impose potential criminal charges against you or civil penalties.

You indicated that you thought that the doctors were complying with this requirement that they not charge their patients more, because you mentioned there are less than 3 percent of nonparticipating physicians that had been sent warning letters.

How many were put on the intensive monitoring? Had any of them been referred to the inspector general? How clear do we have a reading of what, in fact, is taking place around the country?

I think we all agree it would require an enormous bureaucracy to check every physician to be sure that that physician has not actually charged the patient more money, because he certainly is entitled to charge the patient when he doesn't take assignment for his fee.

How do we know they have not raised the charges to those patients?

Dr. DAVIS. We are tracking that, as I indicated. We can estimate that less than 3 percent of the nonparticipating physicians have had a raise of any nominal amount, say beyond \$100.

There is a monitoring process done by computer at the carrier level that tracks this. We have about 8,000 physicians that were sent an initial warning letter. For some of those, we began further inspection of the records, and we found that actual increases were due to coding errors. So more like 4,000 physicians being tracked at this time. For those 4,000, we sent a letter out and asked them to reply in 15 days as to whether or not there was validity to the fact there appeared to be an increase.

We are just at the point of collecting that data and we will be scrutinizing that further. The referrals to the inspector general would come at a later point in time, with one exception, and that is there appears to be a group of physicians in the New York City area that appear not to be accepting assignment, although they had signed up to. The inspector general has the referral on that and is pursuing it at this time.

Mr. WAXMAN. Now, one could expect three possible reactions if physicians were not happy with the situation. Some physicians, if they find that what Medicare pays them is so out of line to what they consider their fee to be, will say, "I am not taking Medicare patients any longer." So there will be a loss of access for some of the Medicare patients.

Another way a physician might handle it is to say, "Well, I get paid on a fee-for-service basis. I am just going to provide more services. I will increase the volume of what I will bill for, and in that way I will get more payments from the Government." And not only that, I can ask for more payment from the patient, because the patient is required to pay theoretically 20 percent, but often it is more than that because the patient makes up the difference of what the physician's bill is when that physician does not take assignment.

A third way of physicians to respond to this is that they can play other games they might well figure out when they are faced with the realization that it is awfully hard, even with your computers, to trace everything a physician does. He can define his service differently. He is not doing what you froze at a certain level; he is doing something that you froze at a higher level.

That is one of the Reagan administration theories. People always told us—there is a grain of truth in it—in a regulatory system that is oppressive, those being regulated can figure out ways of gaming the system. We have had evidence of this in the past when there were price controls under the Nixon administration. Studies showed that this was one of the results; the same thing occurred in Canada when they had some price controls at one point.

Is it your view that if we had an extension of the freeze, that we might see these kinds of results occurring by the physician community?

Dr. DAVIS. No, sir. It is not, for two reasons. As I indicated earlier, at the carrier level we do have a process that does look at the physician's practice patterns over a 6-month period of time and

compares it to the same 6-month period in the previous year. We can detect increased utilization of services and we can actually look to see which specific services those are; and we also check for up-coding which can result from claiming that something is a comprehensive instead of a brief office visit. So those are edits already in the system.

We are now also doing some random prepayment edits to allow for some checks within the system in the prepayment timeframe.

I think we do believe we have the ability to detect any type of volume changes and can move to take corrective action.

In terms of access, it is very instructive to look at what has happened in the last few months. Even though the percentage of the physicians who signed up totally for participation was 30 percent, the volume of claims and the dollars in claims being processed under assignment has grown dramatically. We are now running roughly at the 67-percent level in terms of the claims paid under assignment. I think that is very dramatic in representing a very significant increase.

So what it has shown, I believe, is the increased numbers of physicians in the communities has increased competition so that the more physicians are willing to treat the Medicare patient and are responsive. So we don't believe there would be a problem of access.

The point I was trying to make earlier Mr. Chairman, was in relationship to when I was talking about the salary increases. I was trying to make the point that that the other choice instead of freezing would mean that we would have to increase the dollar outlays, which would again be a problem within the overall budget. It would also impact significantly on the beneficiaries themselves.

Beneficiaries would face an increase in their copayments; they would face an increase in the total charges for the physicians who are nonparticipating; and, additionally, there would be a higher premium. That is important to remember. That was what I was trying to get at.

Mr. WAXMAN. Of course, the administration is proposing increases in the out-of-pocket expenses for premiums and deductibles, and coinsurance for the Medicare beneficiaries under the proposal—not only the one originally before us, but as well the one agreed to with the Senate.

One of the concerns some of us have with the physician freeze is that the patients not only have to pay their deductible for the doctor and their so-called 20 percent of the fee that the Medicare people decided is the reasonable fee, but, in addition to that, the additional charges the doctor would require because he doesn't accept that definition of what is reasonable.

I am going to have to recognize others, and we will have more chance to discuss these because I have other points I want to raise with you, as well. But I want to make one observation.

When some of us went along with this proposal last time around for 15-month freezing, we came to the conclusion that it would work, if at all, because the doctors would voluntarily participate and go along with it knowing it was for 15 months. And, they already agreed on a voluntary effort to freeze their fees. I have a serious question in my mind that if this is required again, after the 15-month period lapses, for another year, they will get the feeling

this is not a temporary matter but a permanent feature of the Medicare Program; and then the resistance will be coming out and it will be a serious question of how we can enforce it and what resources we will need to do that, and whether we will be successful at all.

I say that rhetorically to you, because I am giving my views.

I will recognize my colleagues to explore these and other areas.

Mr. TAUKE.

Mr. TAUKE. Thank you, Mr. Chairman.

Mr. Chairman, you are usually very thorough, but when you listed the possible reactions of a physician to this system you only listed three, and obviously there are at least four, and you missed the most important and widely used one, which is picking up the phone and calling your Congressman.

Dr. Davis, it is good to have you here this morning, and we welcome you. Let me pursue a little different course.

I have had some phone calls from physicians, and invariably, it seems to me, the physicians who recently entered the system are the ones most concerned about it. Could you explain to the subcommittee how physicians who are just beginning private practice establish a profile of customary charges under Medicare?

Dr. DAVIS. Yes.

Ms. KELLY. Mr. Tauke, normally they are recognized at the 50th percentile of charges in the area. That is established as their customary charge.

In any event, we pay no more than the prevailing charge in the area.

Mr. TAUKE. Is it 50 percent of the charges in the area based on 1982 data—Is that it?

Ms. KELLY. Current charges are based on that period, yes.

Mr. TAUKE [continuing]. Do you think this is a fair schedule for the physician that enters the community and has not had any impact on whether or not those physicians are willing to participate in the program?

Dr. DESMARAIS. Mr. Tauke, it is not 50 percent. It is the 50th percentile.

Mr. TAUKE. I am sorry, yes.

Dr. DESMARAIS. There is a big difference, because what that says is that right now with the current freeze half the physicians in that community are already frozen at that level or below. So when the new physician comes in they are paid at the 50th percentile. That has not changed.

Mr. TAUKE. But the other physicians are paid at the 75th percentile; is that not correct?

Dr. DESMARAIS. No, they are paid the lower of their actual charges, customary, which is what the 50th percentile establishes, or the prevailing charges. For those whose customary has historically been above the prevailing, they are paid their prevailing.

Mr. TAUKE. That is correct.

I guess this is the difficulty; that, as I understand it, the new physicians have no customary. So, consequently, they are reimbursed at the 50th percentile of prevailing while other physicians are reimbursed at the 75th percentile, or customary, whichever is lower. But there is virtually no way, as I understand the system—

please explain to me if I am wrong—there is no way that the new physician can get above the 50th percentile because they don't have the customary, and they don't qualify for the 75th percentile prevailing because they are new.

Dr. DESMARAIS. You are correct, except again I would point out that many physicians, established physicians in that community, are also in the same similar situation. In fact, some of them have a customary that is lower than the 50th percentile, and they would be paid that customary, which is frozen, as well. So we don't really feel the new physician is being disadvantaged in any way.

Mr. TAUKE. How long does the new physician go under the current system before the new physician can establish his or her own customary? How does one do it?

Ms. KELLY. Once we have 3 months of charge data, Mr. Tauke, we then update in the following fee screen year.

Dr. DAVIS. That has been past practice, yes.

Mr. TAUKE. Let me ask you this: What kind of participation are you getting from new physicians?

Dr. DAVIS. I don't believe that we have the ability at this point to actually tease out new physicians from physicians who have been in practice in any prior time period.

Mr. TAUKE. Do you have any feel for it, even though you can't pull that data?

Dr. DAVIS. It is not something we have queried our carriers on. We would have to go back and see if we could break that out. We would be happy to do that for the record, if we can find that data.

[The following information was submitted for the record:]

The National Opinion Research Center is conducting a national survey of physicians' practice costs and income for HCFA.

Data collection began in November of 1984 and will continue through May 1985.

Preliminary data from the survey is expected in June of 1985 and final figures in October 1985.

Although we do not have specific data on the participation rates of new physicians versus established physicians, we do have data on participation rates by the age of the physician. Based on preliminary data from 1700 out of a planned sample of 5000, age seems to be less of a factor in explaining participation than other factors such as specialty.

Participation varies by specialty from a low of 22 percent for anesthesiologists to 50 percent for general surgeons.

Participation varies by age from a low of 24 percent for physicians over 65 to a high of 37 percent for physicians between the ages of 35 and 39. Physicians under age 35 have a participation rate of 29 percent.

Mr. TAUKE. Maybe I should ask you: What incentives or disincentives do you see for the new physician?

Dr. DAVIS. I think it would vary according to the community. Clearly, the percentage of participating physicians is different around the country, from a low of 5 percent in South Dakota to a high of about 50 percent in Alabama; enormous variability exists in the country in percentage rates.

I don't think it would be any different in terms of new physicians. I would assume they would emulate similar practices as to what is going on in their local communities.

Mr. TAUKE. OK.

Ms. KELLY. We also have a National Opinion Research Center survey ongoing in HCFA. We have information on 2,000 respondents, and we do not see any significant trends in that direction.

Mr. TAUKE. I still don't have an answer as to what the incentive to participate or not for new physicians may be. I have the impression—maybe I should ask it this way—I have the impression that new physicians are saying to themselves, "With the freeze in effect and with other problems of entering, we are better off not participating." At least that is what they seem to be telling me. I have a very small sample of new physicians.

Now, why are they correct, or why are they wrong? What would you say to a new physician?

Dr. DESMARAIS. They are really not correct. I can tell you that many established physicians feel the new physicians coming into the community generally try to charge more than the established physician already there.

The point I was trying to make—and, again, that would be my answer—is that many of their peers who have given service to the community already are frozen at lower customaries than the one created for them when we use the 50th percentile. So they are no worse off than more than half their own peers in the community, although they are new physicians.

Mr. TAUKE. Dr. Davis, you raised another issue about the differential between some areas of the country and others in participation. I was quite astonished when you said 5 percent for South Dakota.

Why is there that variation?

Dr. DAVIS. Some of it, about a third, seems to be due to historical practices. If there was a tendency in a particular State to have a large participation rate prior to this program, then it seems that that same type of activity carried forward.

Beyond that—we are still trying to determine—we believe that it may have something to do with competition, the number of physicians in a community. That seems to have some relation to it. We hope to tease that out as we complete our study that the National Opinion Research Center is doing for us.

We will be happy to submit for the record the variation from State to State. It is quite significant.

[The information follows:]

PARTICIPATING PHYSICIAN DATA BY STATE

<u>State</u>	<u>Physicians/Suppliers</u>	
	<u>Number</u>	<u>Percent</u>
ALABAMA	3,309	50.2%
Physicians	2,695	53.9
Limited License Practice	229	59.8
Suppliers	385	31.6
ALASKA	82	12.2%
Physicians	52	9.4
Limited License Practice	6	18.2
Suppliers	24	27.9
ARIZONA	1,249	18.7%
Physicians	922	17.9
Limited License Practice	183	19.8
Suppliers	144	23.0
ARKANSAS	1,813	41.9%
Physicians	1,409	44.6
Limited License Practice	184	55.1
Suppliers	220	26.5
CALIFORNIA	18,383	30.4%
Physicians	15,071	29.9
Limited License Practice	2,022	41.1
Suppliers	1,290	24.2
COLORADO	1,496	42.2%
Physicians	1,183	38.0
Limited License Practice	72	63.2
Suppliers	241	75.8
CONNECTICUT	1,513	25.8%
Physicians	1,031	23.3
Limited License Practice	256	42.0
Suppliers	226	27.6
DELAWARE	696	31.8%
Physicians	606	33.3
Limited License Practice	53	52.0
Suppliers	37	13.7
DISTRICT OF COLUMBIA	4,255	49.1%
Physicians	3,832	52.9
Limited License Practice	262	58.6
Suppliers	161	16.5

PARTICIPATING PHYSICIAN DATA BY STATE

<u>State</u>	<u>Physicians/Suppliers</u>	
	<u>Number</u>	<u>Percent</u>
FLORIDA	6,094	24.4%
Physicians	4,599	23.8
Limited License Practice	863	51.4
Suppliers	632	16.1
GEORGIA	3,739	33.0%
Physicians	3,247	34.9
Limited License Practice	236	26.2
Suppliers	256	23.1
HAWAII	710	18.2%
Physicians	610	18.2
Limited License Practice	81	18.0
Suppliers	19	19.0
IDAHO	220	13.2%
Physicians	138	11.0
Limited License Practice	42	24.1
Suppliers	40	16.0
ILLINOIS	5,430	22.7%
Physicians	4,453	23.5
Limited License Practice	624	31.0
Suppliers	353	12.1
INDIANA	1,633	18.5%
Physicians	1,119	19.4
Limited License Practice	7	14.3
Suppliers	507	16.8
IOWA	2,777	34.4%
Physicians	1,975	35.9
Limited License Practice	34	12.7
Suppliers	768	33.6
KANSAS	2,115	49.6%
Physicians	1,664	52.9
Limited License Practice	90	66.7
Suppliers	361	36.8
KENTUCKY	2,369	23.3%
Physicians	1,976	23.3
Limited License Practice	23	15.5
Suppliers	370	23.7

PARTICIPATING PHYSICIAN DATA BY STATE

<u>State</u>	<u>Physicians/Suppliers</u>	
	<u>Number</u>	<u>Percent</u>
LOUISIANA	1,589	27.1%
Physicians	1,393	29.4
Limited License Practice	65	19.6
Suppliers	131	16.3
MAINE	1,055	39.9%
Physicians	741	35.0
Limited License Practice	30	41.1
Suppliers	284	30.9
MARYLAND	2,281	30.3%
Physicians	1,778	30.4
Limited License Practice	99	31.7
Suppliers	404	29.7
MASSACHUSETTS	6,087	47.3%
Physicians	4,608	47.9
Limited License Practice	355	51.4
Suppliers	1,124	43.8
MICHIGAN	8,158	42.3%
Physicians	6,861	43.4
Limited License Practice	797	52.1
Suppliers	500	25.6
MINNESOTA	2,215	19.0%
Physicians	1,778	18.0
Limited License Practice	108	39.9
Suppliers	329	21.9
MISSISSIPPI	845	22.2%
Physicians	618	20.5
Limited License Practice	8	15.7
Suppliers	219	29.8
MISSOURI *	3,918	32.1%
Physicians	3,379	34.1
Limited License Practice	219	39.7
Suppliers	320	18.3

* Includes Kansas City, Kansas.

PARTICIPATING PHYSICIAN DATA BY STATE

<u>State</u>	<u>Physicians/Suppliers</u>	
	<u>Number</u>	<u>Percent</u>
MONTANA	350	18.8%
Physicians	233	19.0
Limited License Practice	12	15.8
Suppliers	105	18.7
NEBRASKA	1,014	25.7%
Physicians	572	22.2
Limited License Practice	143	50.2
Suppliers	299	27.6
NEVADA	826	32.7%
Physicians	756	38.0
Limited License Practice	36	19.3
Suppliers	34	9.7
NEW HAMPSHIRE	570	30.1%
Physicians	389	27.5
Limited License Practice	17	21.8
Suppliers	164	40.9
NEW JERSEY	2,806	20.0%
Physicians	1,993	19.0
Limited License Practice	339	29.0
Suppliers	474	19.8
NEW MEXICO	1,318	44.6%
Physicians	1,132	48.6
Limited License Practice	97	42.0
Suppliers	89	22.6
NEW YORK	10,730	22.9%
Physicians	8,310	21.7
Limited License Practice	761	29.1
Suppliers	1,659	28.2
NORTH CAROLINA	3,991	39.0%
Physicians	3,310	39.4
Limited License Practice	461	65.1
Suppliers	220	19.5

PARTICIPATING PHYSICIAN DATA BY STATE

<u>State</u>	<u>Physicians/Suppliers</u>	
	<u>Number</u>	<u>Percent</u>
NORTH DAKOTA	248	12.8%
Physicians	149	10.4
Limited License Practice	11	26.2
Suppliers	88	18.8
OHIO	6,642	23.1%
Physicians	5,101	22.6
Limited License Practice	708	34.9
Suppliers	833	20.2
OKLAHOMA	1,015	13.8%
Physicians	780	12.8
Limited License Practice	145	21.4
Suppliers	90	14.8
OREGON	967	17.3%
Physicians	561	13.8
Limited License Practice	225	49.1
Suppliers	181	16.7
PENNSYLVANIA	19,304	47.9%
Physicians	15,818	51.1
Limited License Practice	1,947	61.1
Suppliers	1,539	25.1
RHODE ISLAND	853	42.0%
Physicians	730	46.0
Limited License Practice	38	52.1
Suppliers	85	23.0
SOUTH CAROLINA	604	16.0%
Physicians	436	13.5
Limited License Practice	145	48.5
Suppliers	23	8.7
SOUTH DAKOTA	185	10.7%
Physicians	63	5.6
Limited License Practice	39	36.1
Suppliers	83	16.4

PARTICIPATING PHYSICIAN DATA BY STATE

<u>State</u>	<u>Physicians/Suppliers</u>	
	<u>Number</u>	<u>Percent</u>
TENNESSEE	1,887	27.3%
Physicians	1,251	23.9
Limited License Practice	293	57.5
Suppliers	343	29.2
TEXAS	6,987	20.2%
Physicians	6,026	20.2
Limited License Practice	355	24.3
Suppliers	606	18.4
UTAH	886	31.4%
Physicians	703	31.4
Limited License Practice	72	45.3
Suppliers	111	25.9
VERMONT	503	40.9%
Physicians	385	42.2
Limited License Practice	17	40.5
Suppliers	101	36.7
VIRGINIA	2,346	28.1%
Physicians	1,953	28.7
Limited License Practice	175	44.2
Suppliers	218	19.0
WASHINGTON	2,812	26.6%
Physicians	2,271	27.2
Limited License Practice	271	34.0
Suppliers	270	19.2
WEST VIRGINIA	1,243	23.1%
Physicians	1,007	23.1
Limited License Practice	69	36.5
Suppliers	167	20.3
WISCONSIN	3,624	33.8%
Physicians	2,802	34.7
Limited License Practice	154	56.2
Suppliers	668	28.2
WYOMING	259	26.2%
Physicians	176	22.7
Limited License Practice	56	59.6
Suppliers	27	22.9

Mr. TAUKE. Do you know yet if there is any difference between communities where there is a single provider or single physician, and communities where there are many physicians? When you say South Dakota has 5 percent, what leaps to my mind is that perhaps South Dakota is one of those States where there are a lot of single-physician communities, and maybe physicians in those communities are not participating.

Do you have any feel at this point whether or not that would be an accurate assumption?

Dr. DAVIS. I don't know if we know that specifically, but I can point out that I don't think Alabama is notoriously rich in large cities, either. I think there is a fair volume of physicians who practice in small communities there, and yet they are at the top of the list. That may have some bearing on part of it.

As I said, I don't think we know all the reasons why. The Northeast seems to have the highest overall participation rates; and the West seems to have the least numbers in terms of participation rates.

Mr. TAUKE. Let me just ask one other thing—and I know my time has passed by. But I certainly get the strong impression that we are heading down a road that cannot be traveled very far; that we are going to get ourselves into a real mess if we keep trying to regulate prices in this way.

What work is being done to figure out where we go 5 years from now? Is there a major—is there a significant effort being made in trying to prepare some options for change?

Dr. DAVIS. Yes, absolutely. We have several studies going on inside the agency looking at the whole area of physician reimbursement. We have a study that was mandated under the Social Security Amendments of 1983 as to whether or not it is both advisable and feasible to use a DRG system to pay for the inpatient care that physicians render. That represents about 64 percent of all physician payments.

We have that study almost completed. We had an initial target deadline of December, and in the Deficit Reduction Act, Congress upped that to July 1. We are trying to meet that. It will be a little tight.

As part of that study, we took the position that we did not know how to answer the question of advisability related to use of physician DRG's unless we looked at alternative options also. So the report will also include discussions with pros and cons that relate to use of physician fee schedules, relative value scales, the idea of geographic capitation, and other types of capitation systems. All of that will be included in that report.

Mr. TAUKE. Is there any study directed toward getting the Federal Government out of the position of being the payor of services and instead perhaps using a voucher, tax credit, or some other method for attempting to have the individual be the payor?

Dr. DAVIS. There are a couple of studies that are ongoing as they relate to voucher concepts that are not specifically targeted simply for physicians only. One that comes to mind is out in Oregon. In a second area, we are just commencing to do some initial work and we expect to award some contracts this fall. This would be the whole concept of geographic capitation, capitating an entity in a

particular area to give the care to all beneficiaries. That would lead us to the use of vouchers, also. I think those are the concepts we hope will move forward.

Clearly, we need to do some demonstrations in this area before we would be prepared to move in a major way. But we think that that is a very exciting aspect, and that is one of the demonstrations we will move forward with this year.

Mr. TAUKE. Is it reasonable for me to request from you a brief summary of the studies that you have under way on this broad issue of medical care reimbursement?

Dr. DAVIS. I would be happy to provide them.

[The information follows:]

Medicare Capitation Demonstrations

Past Studies

- In 1979, HCFA began to test capitated delivery systems. As a result of a Request for Proposals (RFP) five contracts resulted:
 - o Kaiser (Portland, OR)
 - o Marshfield (Marshfield, WI)
 - o Fallon (Worcester, MA)
 - o Interstudy (Minneapolis, MN)
 - o Health Central (Lansing, MI)
- In these early demonstrations, all reimbursement was capitated, but we tested out various capitation arrangements and risk sharing agreements.
- In 1982, HCFA released another solicitation for Medicare competition demonstrations (HMOs, Voucher Models, Broker Models, and Intermediary-at-Risk). Twenty-one contracts and six grants were awarded to prepaid health plans, predominantly HMOs, as well as one voucher model and one broker model.
- To date, over 300,000 Medicare beneficiaries have enrolled in these HMO demonstrations. Results from these demonstrations were used to develop the TEFRA HMO legislation and design of final regulations implementing TEFRA.
- HCFA contracted with Jurgovan and Blair, Inc. to perform the evaluation of the first set of HMO demonstrations, and Mathematica Policy Research for the second set of HMO demonstrations.
- Highlights of the demonstration include:
 - o HMOs operating under risk capitation will attempt to enroll significant numbers of beneficiaries by aggressive marketing and using savings to offer extra benefits.
 - o Health screening tested in one of the demonstrations led to biased selection (favorable to the HMOs). Health screening is not allowed under TEFRA.
 - o A benefit stabilization fund tested in one site resulted in less fluctuation in premiums over time. This concept was incorporated in subsequent legislation.
 - o Administration of the HMO demonstration contracts was facilitated by new hospital billing options, new and faster methods of disenrolling enrollees, independent reviews of quality assurance by PROs and the National Committee for Quality Assurance, and reminder letters to new enrollees of the lock-in requirement.
 - o Based on satisfaction surveys, 88 to 99 percent of all enrollees reported they were satisfied with the care they received.

- On April 1, 1985, most of the HMO demonstrations converted to the TEFRA HMO program, making the benefits of HMOs permanent for HMO enrollees.

Ongoing Studies

- Some of the demonstrations resulting from HCFA's 1982 RFP are still continuing. These are not TEFRA projects, and each is testing a new concept.
 - o HealthChoice disseminates information to all area beneficiaries and conducts counseling sessions. HealthChoice sends a voucher equivalent to 95 percent adjusted average per capita costs (AAPCC) to beneficiaries. It can only be redeemed through HealthChoice, which is able to enroll beneficiaries on-site into three HMOs.
 - o Senior Health Plan HMO is testing a modification to the standard AAPCC reimbursement method. Prior hospital use and Part B deductible status are used with age, sex, and welfare to derive prospective capitation rates. An evaluation of the demonstration will determine if this additional refinement improves the accuracy of the prospective AAPCC.
- HCFA has approved five HMO demonstrations that will test a lower level of reimbursement. Each HMO has agreed to receive 85 percent of the AAPCC. The HMO will meet all TEFRA requirements, except that savings do not have to be returned to the beneficiary. Each HMO is located in a competitive area and will compete with other TEFRA HMOs receiving 95 percent AAPCC.
- Social HMO Demonstrations
 - o HCFA is testing an extension of the HMO model in which long term care services (case management, homemaker/ home health and other community-based services) are included among the usual acute and preventive services. All Medicare services will be provided by, or under arrangements made by, organizations at a capitation rate of 100 percent AAPCC.
 - o These projects extend the insurance model to long term care services and include a joint partnership with State Medicaid agencies and HCFA in which funding is pooled.
 - o The demonstrations were congressionally mandated.
 - o Four Social HMOs started operation in March 85 and will be evaluated over a 3-year period:
 - Kaiser (Portland, OR)
 - SCAN (Long Beach, CA)
 - Elderplan (Brooklyn, NY)
 - Ebenezer (Minneapolis, MN)

- Long Term Care

On Lok's Capitation Demonstration

- o Demonstration congressionally mandated by Social Security Amendments of 1983
- o Establishes a Medicare capitation payment, based on AAPCC for the institutionally-certified elderly.
- o Demonstration involves 300 frail elderly.

- ESRD

- Competitive Models in ESRD - Urban Institute

- o Urban Institute will determine feasibility of capitation, competitive bidding, and voucher approaches for reimbursement for ESRD services.
- o Capitation approaches will consider both--
 - Global capitation system for ESRD patients which includes all medical care costs
 - Partial system, which covers only outpatient services
- o Final report on capitation study due March 30, 1986.

- El Camino Health Maintenance/Disease Management Organization

- o El Camino Hospital (Mountain View, California) awarded grant in December 1984 to develop capitation payment program covering all Medicare benefits including transplants for ESRD patients.
- o An HMO-like system—a "Disease Management Organization" (DMO) would be developed. Reimbursement will be at 95 percent of fee-for-services rate.

Planned Studies

In ORD's April, 1985 grant and cooperative agreement solicitation, we have proposed capitation demonstrations in the following areas:

- Voucher to the Beneficiary

- o Our solicitation requests proposals that would test the direct provision of vouchers to Medicare beneficiaries for the purchase of health services.

Refinements to the AAPCC

- o Through research of existing data bases from HMO demonstrations, ORD has developed a modified AAPCC method using prior Medicare use as a measure for health status. It is being tested in the Senior Health Plan HMO demonstration.
- o Others are being developed, including refinements to the AAPCC using additional adjustors, such as prior use adjusted for diagnosis and measures of disability. These models will also be tested in demonstrations.

Intermediary-at-Risk

- o In this capitation concept, a current Medicare intermediary/carrier would accept risk for all Medicare services and administrative costs in a given geographic area for a fixed amount paid prospectively by HCFA for each beneficiary.
- o Beneficiaries retain freedom-of-choice, thus they have available to them the full Medicare benefits available through the traditional Medicare delivery system.
- o Organizations may market their own alternative health plan(s). No restrictions may be placed on TEFRA HMOs or CMPs.
- o We have discussed this concept with some intermediaries and have told all of HCFA's intermediaries that we are interested in receiving proposals from them to demonstrate the concept.

Dr. DAVIS. I would like to add also that we had a conference this past January that tried to lay out for individuals who were interested—I think we had a large attendance of the provider community—all the various studies we have been funding on physician reimbursement. They had a 2-day conference here in Washington that was hosted by Project Hope, which is our contractor. It spent a great deal of time going through many different studies, transcripts of that are available.

Mr. TAUKE. Thank you. I would appreciate a copy of that, too, if you could send it my way.

[The information follows:]

The Evidence On Medicare Physician Payment Alternatives

January 16-17, 1985
The Mayflower Hotel
Washington, D.C.

A Forum on Health Care Financing Administration Funded Research

The Evidence On Medicare Physician Payment Alternatives

Wednesday Morning, January 16
Moderator: Gail Widenky, Ph.D.,
The Project HOPE Center for Health Affairs

9:30 Welcome

Patrice Feinstein, HCFA Opening Remarks
Stephen Jencks, M.D., HCFA - Conference Overview

9:50 Background Issues to Physician Reimbursement

Kathryn Langwell, Mathematica - Physician Payment Systems:
A Review of History, Alternatives, and Evidence
Louis Garrison, Ph.D., Project HOPE Center for Health Affairs -
Aging Population, Increasing Physician Supply, and the
Physician Services Market
David Juha, Ph.D., Urban Institute - Decomposing Part B
Payments for Physician Services, 1975-1983

10:35 Break

10:50 Administrative and Feasibility Issues of Physician Reimbursement

Mark Pauly, Ph.D., Leonard Davis Institute, University of
Pennsylvania - Who Shall Be Paid?
Janet Mitchell, Ph.D., Health Economics Research
Alternative Classification Approaches to Physician
Reimbursement
Janet Mitchell, Ph.D. - MDDRGs: What Do They Look Like and
How Well Do They Work?

12:00 Lunch Break

Wednesday Afternoon, January 16
Moderator: Louis Rossiter, Ph.D.,
Medical College of Virginia

1:30 Administrative and Feasibility Issues of Physician Reimbursement cont.

Mark Moskowitz, M.D., Boston University
The Clinical Appropriateness of MDDRGs
Discussion Panel: Robert Derzon, Lewin and Associates
Stan Finkelstein, M.D., The Sloan School,
Massachusetts Institute of Technology
Steven Schroeder, M.D., University of California at
San Francisco

2:30 Unit of Payment Alternatives

Gail Wilensky, Ph.D., Project HOPE Center for Health Affairs -
Alternative Units of Payment: An Overview
Jerry Cromwell, Ph.D., Health Economics Research
Packaging Physician Services for Payment Purposes

3:10 Break

3:30 Unit of Payment Alternatives, cont.

Lynn Etheredge, Ph.D., Urban Institute
Unit of Payment and Volume
Stanley Wallach, Ph.D., Health Policy Center, Brandeis -
Capitation for Physician Services on a Geographic Basis
Discussion Panel: James Morone, Ph.D., Brown University
Julian Pettengill, Congressional Research Service
John Wennberg, M.D., Dartmouth Medical School

Thursday Morning, January 17

Moderator: Louis Rossiter, Ph.D.

9:30 Setting the Reimbursement Amount

Frank Sloan, Ph.D., Vanderbilt University
Pricing Options for Physicians Under Medicare: An Overview
Joel Hay, Ph.D., Project HOPE Center for Health Affairs
Competitive Bidding and Consumer Incentive Pricing
Robert Berenson, M.D., Physician Fees: The Theory of Relativity

10:30 Break

10:45 Setting the Reimbursement Amount, cont.

Mark Moskowitz, M.D., Boston University
Seeking the Just Price: Relative Value Scales and Fee Schedules
Discussion Panel: William Hsiao, Ph.D., Harvard University
Wendell Primus, Committee on Ways and Means,
U.S. Congress

11:45 Question/Answer Period

12:30 Lunch Break

Thursday Afternoon, January 17

Moderator: Gail Wilensky, Ph.D.

1:45 Comments

John Iglehart, Editor, *Health Affairs*, Project HOPE

2:15 Physician Roundtable Discussion

Moderator: William B. Walsh, M.D., Project HOPE
Participants to be announced

3:00 Closing Remarks

Gail Wilensky, Ph.D., Project HOPE Center for Health Affairs

About the Conference

This conference will provide a public forum for HCFA funded physician reimbursement research. HCFA will consider this research when it prepares its report to Congress on physician reimbursement under Medicare, to be presented next summer.

About Project HOPE

For more than a quarter century, Project HOPE has improved world health by exporting the skills and resources of American medical professionals and corporations. Best known for the U.S. HOPE, the world's first peacetime hospital ship, HOPE medical education programs have trained health professionals in more than 30 countries. Project HOPE is supported by charitable contributions from American citizens, corporations, and foundations, and by grants from the U.S. government for specific programs.

The Project HOPE Center for Health Affairs is a private, nonprofit policy center that provides objective research and policy analysis to help develop solutions for problems in the U.S. health system. Founded in 1982 as part of Project HOPE, the international health organization, the Center has a special interest in the role of the private sector and state and local governments in moderating the rise of health expenditures.

Mr. TAUKE. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Tauke.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

Dr. Davis, it is my perception, talking to people around the country, there is a tremendous amount of confusion associated with these changes on all sides of the issue: among beneficiaries, doctors carriers, and the public. I think you three may be the only ones in America really who understand all of this.

My first question to you is, have you, in the course of your monitoring, picked up the same kind of confusion and frustration that I have from my constituents? I have had doctors come to me and say, "I signed up to be a participating physician. It has been so poorly run, I believe it has almost been sabotaged. Can you help me?"

Have you picked up this confusion? I think it is near chaos.

Dr. DAVIS. I wouldn't label it "near chaos." I think there was initial confusion in the early time period because of several things happening at once. The laboratory fee put in as part of the DEFRA served to add to that.

Second some of these proposals were retroactive, so that of course, that added to part of the problem in the initial time period. However, we indicated before the physicians signed up that we would be willing to ask the carriers to give them a profiling of their charge pattern so they would have that in order to determine whether or not they would like to accept assignment.

To the best of my knowledge, those were provided where they were asked for.

Mr. WYDEN. You don't think there is a lot of confusion out there today?

Dr. DAVIS. I think there was some confusion in the initial time frame, yes. We had an enormous job of informing 30 million beneficiaries and roughly 400,000 physicians of what was going to be happening to them within a very tight timeframe.

If you remember, I spoke about the fact that we literally had less than 90 days to institute the program. That, I think, was a time period where there were also other activities going on.

What we are trying to do in terms of setting up our monitoring system is very purposefully to send warning letters, but then to also say to our carriers, "Before you take further action, we want you to have received information from the physician. If there still appears to be any pattern of violation, we want you to have a personal contact with him, either face to face or by telephone."

I think the conference committee was very clear; they did not wish to have sanctions taken unless there was willful and knowing abuse of the system. And it is important from our point of view, that we make sure that type of activity is occurring.

Ms. KELLY. Mr. Wyden, I would like to add that we did individual mailers to each one of our 30 million beneficiaries that were specific to that area, giving carrier phone numbers to call if they had questions. We mailed individual letters to physicians explaining the provisions of the law to minimize any confusion as best we could.

Mr. WYDEN. No one doubts that a tremendous amount of paper has been passed around, but my own perception is that there is a

tremendous amount of confusion that has not been sufficiently made clear.

Dr. DAVIS, the second question I wanted to ask is that today, a lot of doctors are taking assignments on a case-by-case basis, rather than participating in assignment for all patients.

My concern is that your proposals would give these physicians, these key players, no incentives in the future to take assignment, and I think it also would remove the incentives to try to get new physicians that my colleague from Iowa was talking about, to become participating physicians.

Do you agree?

Dr. DAVIS. No, sir, I don't, because it seems to me that if you freeze physician fees for another year, and you say to those physicians that are nonparticipating, we will not recognize your charge pattern, but you say to the participating physicians, we will recognize yours, there is a powerful incentive there for the physician to wish to participate.

Mr. WYDEN. The chairman asked you whether or not these changes might cause doctors to increase the volume of their services, or in effect, upcode their services, and you said, as I understood it, that you could detect if this was going on, but how can you prevent it from taking place?

Dr. DAVIS. During our monitoring. As I indicated, much of the monitoring system is a postpayment audit, but we also have a new prepayment screen that will audit certain types of claims.

We can detect some problems before they happen. On the other hand, if there is a history of a pattern, we can also move to take corrective action which can be anything from an educational program, if we think there is simple confusion, to outright sanctions if a problem appears to be abuses of the system.

Mr. WYDEN. Could you tell me, in simple terms, what the White House-Senate agreement on to this issue means for a doctor, and what it means for a consumer?

Dr. DAVIS. That agreement simply speaks to the fact that the participating physician would be allowed to raise their charges which that would be recognized, and the nonparticipating physicians would continue in the freeze.

What that means to the consumer is that those physicians who have been participating would continue to participate. I don't see as there would be any impact on the consumer at all other than as I indicated earlier. It seems to me that if we don't continue with the freeze, then there is an impact on the consumers.

Mr. WYDEN. So, under the White House-Senate agreement, the participating physicians would get an increase in their customary charges, or their prevailing charges, or both?

Dr. DESMARAIS. That is a level of detail that has not yet been worked out. The important point about the compromise is that for those who have been participating physicians, that participation will be acknowledged and their Medicare-allowed charges will be allowed to increase.

They will get more reimbursement.

Mr. WYDEN. I want to yield to the chairman, but I think this is central to making sure that consumer protections are built into whatever is going to come out of this agreement.

Mr. WAXMAN. This is not an inconsequential detail. It means whether the physician is going to actually receive more money from the medicare system or not.

Now, if you freeze the prevailing charge, the customary charges are higher than the prevailing charges under many circumstances. Isn't that right?

Dr. DESMARAIS. Customaries are frequently lower. They may be higher, but frequently lower.

Mr. WAXMAN. Do you know what percentage are higher or lower?

Dr. DESMARAIS. I don't.

Mr. WAXMAN. My understanding is two-thirds are higher, so if you freeze the prevailing charges, the physician will never receive any more money, even though he can make a paper notation that his customary charges were higher.

Dr. DESMARAIS. The true intent of the compromise is to allow increased medicare reimbursement to those physicians who participated. The details of exactly how that will be done and which charges will be used to update the prevailings and/or the customaries will need to be worked out through the legislation.

Mr. WAXMAN. We will hold the record open in that regard. Thank you.

Mr. WYDEN. Dr. Davis, as I said, I think your freeze proposal freezes a lot of inequities in today's system, and it will undermine some of the important incentives we need to get people to become participating physicians. But more than anything, what concerns me is that you are looking for short-term budget savings rather than trying to change the incentives in the system.

It is the incentives in the system that are so perverse, that are dictating this kind of charge-based arrangement, and I think that is why we are going to have problems in the years ahead.

Mr. WAXMAN. The gentleman's time has expired.

Mr. Nielson.

Mr. NIELSON. Thank you, Mr. Chairman.

I would like to comment briefly on my colleague's question.

Mr. Tauke is quite concerned about the new physician. He has the best of both worlds, he can choose the community where the average cost is the higher, where the 50 percentile is higher.

He knows what he can charge. He can charge more than 50 percent of the present physicians in that area. He gets more to start with than those who have been practicing for so many years, and he actually has a real good deal.

My concern is with the one who is there. How does the man who has held his rates down over the years, how does he ever regain or gain on his fellows who have been overcharging over the years, I should say overcharging, but charging at a higher rate for the same thing.

How does he ever gain on those people or the newcomer who immediately comes in ahead of him?

Dr. DAVIS. We have never put forward the freeze proposal as the final solution to our physician reimbursement reform. In order to recognize those kinds of basic differences, we need to have a total system reform.

That is the thing that we are working on now, but as I indicated, those proposals would not be available and appropriate for instituting this next fiscal year.

It is our belief that we need a little bit more work on that, but almost everyone recognizes the time has come for significant reform in that whole area.

Mr. NIELSON. Would you agree that the new physician actually has a better shot than the existing physician, who is charging on the lower end of the scale?

Dr. DAVIS. It would be difficult for me to make a judgment. Some of the new physicians would feel that they don't have, and other ones might accept that philosophy that because they have the opportunity to settle in a new community—

Mr. NIELSON. I don't agree with Mr. Tauke on that point. The new physician has a lot more flexibility than the one who has a record for charging in a moderate rate. Is the Senate compromise, is that a way to get more people to participate? You are giving them a slight increase and not allowing the nonparticipating physician to have them.

Is this a subtle way of saying, some of you ought to come into the participating status, more of you than are there now?

Dr. DESMARAIS. I think in part the reason is to respond to the concern of beneficiary groups, in particular, that if you don't reward those who are participating, they may not continue to do so, and in part, the compromise may be to recognize that.

The other area that has not yet been worked out—if you have not been participating, then you begin to do so in October 1985—is how will your charges be calculated? That is a level of detail that has not been arrived at.

Mr. NIELSON. It is a subtle way of getting more people to participate?

Dr. DESMARAIS. It could be.

Mr. NIELSON. If you are planning to implement the freeze, what are you planning to do about the components to the physicians fees, supplies, equipment, and most especially, the medical malpractice insurance?

What can you do in any of those areas?

Dr. DAVIS. When you speak about the components of the practice, speaking of supplies, things of that nature, we are proposing to freeze all of part B, so that the suppliers would also have freezes on.

If you notice, the freeze is really a proposal across the board for all providers this next year.

Mr. NIELSON. You are going to freeze the supplies and equipment. What about rent, malpractice, things like that?

Dr. DAVIS. Those obviously would not be within our control, no.

Mr. NIELSON. OK.

In other words, you have no plans because you have no authority over those areas. Have you looked at the insurance industry, the malpractice question, and are you planning to bring some action—I am not against the insurance industry, but I also wonder if the judicial system has not been so generous on malpractice cases that it has made those fees, and I am not blaming the insurance industry,

but blaming some combination of the judicial system, and the insurance industry for causing that problem.

I spoke on a plane with a man who is a neurosurgeon. He does approximately 800 cases a year, and that is about all he can handle. The malpractice insurance went up such to the extent he will have to charge \$500 per case, just on the malpractice part of that fee.

He may be an exceptional situation, New York City. My guess is, he is going from \$200 to \$500 per person because of malpractice insurance. That has got to put pressure on his fee?

Dr. DAVIS. You are speaking to a problem that we are aware of. We think it is a limited problem for limited specific groups. From the data source that we have, it indicates that 75 percent of the physicians have premiums that are less than \$10,000 a year, but it is a problem that we are collecting data on.

We are beginning to study that, and I know that some of your colleagues here in Congress already are shaping a bill, if they have not introduced it yet, I believe they will be shortly, that deals with that whole issue of malpractice.

Mr. NIELSON. A couple of quick questions, What happened to the number of doctors who accepted assignment? Is it increasing, decreasing or staying the same? Can they come in and out of the system, or once they accept assignment, they stay on forever.

Dr. DAVIS. It is a once a year. They can sign up at the beginning of the year.

Dr. DESMARAIS. That is for participating physicians, but physicians can continue to accept assignment on a claim-by-claim basis.

Dr. DAVIS. That has been growing.

Mr. NIELSON. What has happened to the number of doctors who are accepting assignments on a usual basis?

Dr. DAVIS. That percentage is approximately 30 percent.

Mr. NIELSON. Increasing or decreasing?

Dr. DAVIS. They have only the one-time period.

Mr. NIELSON. Do you expect it to increase or decrease?

Dr. DAVIS. Because of the number of new physicians coming out and the competition, we would expect to see that increase.

Mr. NIELSON. The geographic distribution of those people. Suppose I come from a community where none of the physicians will accept assignment and my neighboring town has some physicians who will accept? Does that put me at a disadvantage if I am a customer?

Suppose I live in a community where there are no participating physicians as compared with another one maybe down State, where there are a number of them, does that give me a disadvantage as far as my shopping around?

Dr. DAVIS. Well, it would mean that you would have to negotiate with the nonparticipating physician to find out whether or not they would accept assignment for your claim, and some physicians are obviously doing that because the percentage that are being accepted under assignment has grown.

Mr. NIELSON. What about the distribution by speciality?

Dr. DAVIS. The distribution by speciality—

Mr. NIELSON. Are there some specialties where people will participate more often than others?

Dr. DAVIS. Yes, they tend to be in the area of radiology and pathology, which run approximately a 40-percent participation all of the time.

Surgery, I believe, runs about 34 percent, and at the lower end of the spectrum is family practice at 25 percent and general practice, 27 percent.

Mr. NIELSON. So I might have a problem either geographically or by specialist.

Dr. DAVIS. The beneficiary would have the opportunity, of course, to have access to these directories which are by geographic locality, and they could then, either through looking at the directory or through contact with the carrier, obtain the information.

If they chose to seek somebody who accepts assignment, it would be their choice to receive their care in a nearby community.

Mr. NIELSON. I have a question. Is this listing of participating physicians, is that sort of a blacklist? Does that say, if you are not on that list, you better not look to these people?

Dr. DAVIS. I view it as a help. I stated it that way because in talking to the beneficiaries as well as talking to the physicians who are in a participation status, they view it as a very helpful activity.

From the beneficiaries' point of view, I think the directories have been rather significant—clearly, when we have sold 17,000-plus of them, it indicates some degree of interest. I have talked to physicians who indicate to me that because their name is in the book, they believe they have actually increased their practice.

There is an additional book that we refer to as our PARL book, which lists all physicians and the percentage of claims that they take under assignment. That book is also available, and was widely distributed.

It has not been a best seller. We have sold less than 200 copies of that one.

Mr. NIELSON. I have one more question. Supposing I am a doctor who charges \$10 for an office call, I know I am talking about some time ago, and supposing the prevailing wage—

Mr. WAXMAN. That was for a house visit, \$10?

Mr. NIELSON. I am older than the chairman. He is much younger. Suppose I charge \$10 for whatever. Supposing the individual customary fee for the community or the prevailing wage is \$20.

What is my incentive to ever participate, because you are going to give me \$10 and everybody else is going to get \$20? Why shouldn't I decide I am not going to participate, and start raising my fees, because I have been undercharging all these years, until I establish a record of higher fees, and then I will participate when you base it on my later fees?

Dr. DAVIS. Clearly, there wouldn't be anything to prevent you from doing that. It is a personal decision as to whether he wishes to participate or not, and we clearly supported that over a mandatory assignment which we thought would be much more intrusive into physicians' decisionmaking.

Dr. DESMARAIS. If you participate, you also can begin to charge higher amounts, and although you may not immediately get paid more, that would be taken into account at a later time.

Mr. NIELSON. I would get paid the \$10 even though the prevailing is \$20, according to my information.

Dr. DESMARAIS. That is true at that point in time.

Mr. NIELSON. At what point do I ever catch up? Did I have to go to the subterfuge of refusing to participate and gradually raise my fees later?

Dr. DESMARAIS. In a freeze, if you don't participate, you are right. You can't increase your customaries and prevailings. If you do become a participating physician, you can bill higher amounts and medicare, at some future time, will increase your customary.

There is an advantage, if you will, although it is not an immediate one, but the immediate one would be to get your name in a book and to advertise it, and to allow beneficiaries to identify you as someone who they may wish to seek care from.

Mr. NIELSON. Doctors in hospitals say if all the doctors in the hospital want to participate, then everybody has to, or conversely, if the majority don't want to participate in the hospital, none of them can.

Are those stories true? Are we doing this on a hospital-by-hospital basis?

Dr. DAVIS. We have not heard that, sir.

Mr. NIELSON. I can give you some documentation. Please give me a list for the record of the geographic distribution of percentage of participants. I would like to see that also by speciality, to see wherein we may be having some trouble.

Dr. DAVIS. We would be happy to provide that.

[The information follows:]

Medicare Participating Physicians and Suppliers

National Specialty Data

<u>Specialty</u>	<u>Number of Participants</u>	<u>Percentage of All Physicians/ Suppliers</u>
<u>Physicians (M.D.s and D.O.s)</u>		
General Practice	13,743	27.3%
General Surgery	9,491	33.9%
Otology, Laryngology, Rhinology	1,741	24.6%
Anesthesiology	3,269	21.1%
Cardiovascular Disease	3,820	35.6%
Dermatology	2,089	34.0%
Family Practice	8,820	25.5%
Internal Medicine	21,067	32.5%
Neurology	2,543	34.8%
Obstetrics-Gynecology	6,704	29.1%
Ophthalmology	4,220	27.3%
Orthopedic Surgery	4,096	29.0%
Pathology	2,263	39.6%
Psychiatry	6,871	30.0%
Radiology	6,658	41.3%
Urology	2,381	27.8%
Nephrology	944	50.8%
Clinic or Other Group Practice-Not GPPP	6,795	33.8%
Other Medical Specialties	6,515	32.4%
Other Surgical Specialties	4,398	18.2%
<u>Limited License Practitioners</u>		
Chiropractor	6,217	25.4%
Podiatry - Surgical Chiropody	4,541	38.2%
Optometrist	6,148	44.0%
Other Limited License Practitioners (Audiologists, psychologists, physical therapists)	2,845	36.8%
Independent Laboratory	1,698	28.4%
Durable Medical Equipment Suppliers	5,018	22.7%
Ambulance Service Suppliers	2,551	28.6%
Miscellaneous Suppliers (Orthotists, prosthetists, portable x-ray suppliers)	8,555	22.5%
Grand Total	156,001	29.4%
Total Physicians	118,428	29.8%
Total Limited License Practitioners	19,751	34.0%
Total Suppliers	17,822	23.8%

N.B. Specialty distribution by geographic area is not available.

Mr. WAXMAN. Dr. Davis, I would be interested to know how much we do know about the present experience with the freeze. Can you furnish us information on that, and do you know at the present time whether we have actually saved money?

Dr. DAVIS. We track our savings over a year's time period. I would have to check with our data people to find out if they can give something before the year is over.

I believe we do it by quarter. I guess the first two quarters are now in.

Mr. WAXMAN. Do we have information at all about this time, about changes in the volume of service mix as a result of the freeze?

Dr. DAVIS. I think our data in that respect are still somewhat preliminary, although that report is in its next-to-final stages, because it will be ready by July 1.

Mr. WAXMAN. Our staff has talked to your staff people to try to find out what we do know. According to the report I got back, there is really very little we do know, because you will not be able to figure it out until the year is up. Therefore, we are working on assumptions that may not be accurate. Because we don't have the data to learn from the experience we have had with this one 15-month period of a freeze, we don't know whether we are going to save money if we extend it beyond that.

You say you will, and obviously OMB believes you will. We need to know whether we saved the money, what effect the freeze has on the physician-practice mix, and what were the consequences. We know who signed up to be a participating physician, but we don't know whether those who didn't sign up are taking assignments more or less often.

These are important data and, if you can give us anything now, it would be helpful and we will hold the record open.

Dr. DAVIS. We will have more data than we had even just a couple of weeks. We only had one quarter in then. We now have two quarters of data in.

Mr. WAXMAN. How are we going to deal with physicians who turn around and decide this whole system is so oppressive, they are not going to participate, or take assignment, and will ask their patients to pay more to make up the difference for what they think their fee should be?

Your answer was, we will know about it, because the computer systems are sensitive enough to know about it. We will also know if they increase their volume to game the system.

What are we going to do about it? Are we going to have to have an enormous enforcement effort all over the country? Are we prepared to do that?

Dr. DAVIS. I don't believe we need an enormous enforcement system, and the valid data we do have indicate that it is a very small percentage of individuals who apparently have the need for a warning letter.

The clear mandate from Congress in terms of going to a sanction against physicians was to establish willful and knowing violations. That is clearly the area that we will be continuing to monitor.

It seems to me that majority of the physicians, however, from what we can tell, are not increasing their volume and abusing in the system.

The computer part itself is not a major activity. It is true, we had to take the time to put the edits in, but once they are there, they are like any computer system.

Mr. WAXMAN. The point I am making is not something that would be in violation of the law. If they start gaming the system on volume and patient service, they can do that legally, and there is not much you can do about it except to acknowledge that fact.

Second, I think you are probably right about physicians for the most part going along with what we put into place, because they are voluntarily doing it.

That is the reason why you may see little experience to the contrary, but the question I will ask, in a rhetorical way is, how much anger are we going to have from the physician community that will feel that we lied to them when we put the freeze into place, and told them it will only be for 15 months, and then we go ahead and put it in almost as a permanent feature of the Medicare system, freezing their fees at 1982 rates?

How long are people, who are going to be resentful, and legitimately so, going to want to be such good guys and participate and not to figure out all the obvious ways there are for them to abuse it. How long will they do what you think you would like them to do, and what we would hope they would do? There is no way to know except a few experiences we have had in the past with price controls and our individual analysis of human nature.

The last point, to follow up on the comment you made in response to a question from Mr. Nielson, there is no way you could freeze the charges to doctors when they buy their supplies from suppliers. All you can do is freeze under Medicare part B what the Government will pay for those particular supplies.

Those suppliers can continue to charge the doctor for the full amount. The doctor will have to come up with that amount, and try to pass it on to the patient. But, we are preventing the doctor from passing it on to the patient.

Dr. DESMARAIS. You are just pointing out what a freeze is, and whether it is somebody's salary or something else, the rent keeps going up. It is not a significant amount of money for the individual physician, and they are able to accommodate that.

Mr. WYDEN. If the chairman would yield for two comments, I think this program degenerates to a shell game. Costs are just being passed on to somebody else, and we know who that someone also is: it's the senior citizens.

Second, we are going to be hearing testimony later, Dr. Davis, that some procedures are simply priced too high and could be reduced. I have met with doctors and other health care providers who say that some procedures are being priced too low, and we need to raise them. This is a clear example of how your freeze freezes the inequities in the system.

What is your reaction to that?

Dr. DAVIS. We believe in the long run, in order to straighten out the perceived inequities in this system, that there is a potential

that one could use something called a relative value scale—but that would take time to develop.

I don't know how one could make an immediate correction, for everyone that has pointed out to me that they are paid too low, I have others that they tell me they were paid too high.

Mr. WYDEN. Do you agree that today's freeze gives some people too much and some too little?

Dr. DAVIS. It carries the same inequities as the previous system did.

Mr. WYDEN. Doctor, anybody who has listened to you, and I have on many occasions, knows you are a very decent and very able person, but I just think the Office of Management and Budget is making too much of the health care policy in this country. We are seeing again and again that their focus is on short-term budget savings and I think we will regret that focus in the years ahead.

It is always good to work with you.

Dr. DAVIS. Thank you.

Mr. WAXMAN. Mr. Nielson.

Mr. NIELSON. I just want to thank the panel for their frankness in answering the questions. I agree with the chairman, though, equipment, supplies, you can't limit it by act of Congress, but I also recognize that the reason you do some of these things is Congress mandated it.

They are the ones that said you had to put out manuals, and I know that is the case. However, it constitutes somewhat of a blacklist in effect, and you don't make much incentive to join the system by the way you treat the nonparticipating physicians.

I would like to say, Carolyne, you send me all those letters from Reader's Digest in addition to this job.

Dr. DAVIS. This job is quite enough. There is not a K in the other one, however.

Mr. NIELSON. Very difficult job, as I said earlier. We must hold health care costs down in an equitable way. That is not easy to do. I hope we can come up with a solution that is fair to the medical community and also to the recipients of the service.

Mr. WAXMAN. Thank you very much, Dr. Davis.

Our next witness is Dr. Rogers Coleman, Blue Cross and Blue Shield of Texas, accompanied by Alan Spielman, the National Office of Blue Cross/Blue Shield. Please proceed, Mr. Spielman.

STATEMENTS OF ALAN P. SPIELMAN, EXECUTIVE WASHINGTON REPRESENTATIVE, BLUE CROSS AND BLUE SHIELD ASSOCIATION; AND ROGERS K. COLEMAN, M.D., ASSOCIATE MEDICAL DIRECTOR, BLUE CROSS AND BLUE SHIELD OF TEXAS

Mr. SPIELMAN. Mr. Chairman, members of the subcommittee, we appreciate this opportunity to present our views on the Medicare physician fee freeze and Participating Physician Program.

Before introducing Dr. Coleman, who will comment from the perspective of a Medicare part B carrier engaged in the day-to-day implementation of these provisions, I would like to offer our observations about the overall trends that appear to be emerging, recognizing that it is too early in our view to reach any firm conclusions.

First, the participating physician program appears to be working. Beneficiary and physician understanding of it is increasing, and importantly, the overall claims assignment rate has increased dramatically.

Second, it appears that the fee freeze requirements are being adhered to by the vast majority of physicians. Also, while sufficient data are not yet available to reach any conclusions, a number of carriers tell us that they have not yet seen increases in utilization in response to the freeze. Formal study of these trends is, however, needed.

The administration has proposed a simple extension of the freeze. We oppose this because we believe it would have a negative effect on the Participating Physician Program.

This program promises substantial beneficiary protection and, in our view, incentives to participate in it should be maintained or strengthened, not reduced.

For the long term, we believe that the best approach to the assignment issue would be to eliminate the current claim-by-claim assignment option while providing strong incentives for physicians to accept assignment on 100 percent of their cases.

Dr. Rogers Coleman, associate medical director of Blue Cross and Blue Shield of Texas, will now comment on his experiences and also will comment on some of the practical effects of various legislative options concerning the fee freeze.

[The prepared statement of Mr. Spielman follows:]

TESTIMONY

OF

BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and members of the subcommittee, I am Alan P. Spielman, Executive Washington Representative for the Blue Cross and Blue Shield Association, the national coordinating organization for all Blue Cross and Blue Shield Plans. Our Association and Member Plans perform Medicare intermediary and carrier functions under contract with the Health Care Financing Administration. In addition, Blue Cross and Blue Shield Plans are the source of private supplementary coverage for 9 1/2 million Medicare beneficiaries.

I am pleased to share with the Committee our perspective on Medicare's physician fee freeze and participating physician program. Joining me today is Dr. Rogers Coleman, Associate Medical Director of Blue Cross and Blue Shield of Texas, the Medicare Part B carrier for the state. Dr. Coleman will be sharing with you the Texas Plan's experience in implementing the current law and his observations about the effect of various legislative options regarding the Medicare fee freeze.

At this point we believe it is too early to reach any definitive conclusions about the effects of the fee freeze and the participating physician program. We would, however, like to offer our observations about the trends that appear to be emerging.

First, the participating physician program appears to be working. This new program, under which physicians and suppliers agree to accept assignment on all Medicare claims, appears to be responsible for increasing the assignment rate to 67% of all claims. This increase in the assignment rate represents a significant achievement in improving the financial protection of beneficiaries. In addition, beneficiary and physician understanding of the new program is increasing.

Second, the fee freeze, by its design, has restrained Medicare payment levels and, for the most part, appears to be protecting beneficiaries against increased financial liability when they receive services from non-participating physicians. We know that violations have occurred, but continuing efforts to educate physicians and beneficiaries and the administration of sanctions where warranted, will help to keep violations at a minimum. Also, while it is too early for definite trends to be documented, we have not yet seen an increase in utilization typically associated with payment freezes. The incidence of coding creep and inflating charges to non-Medicare patients will need to be evaluated. Further studies, such as the one the Health Care Financing Administration will be submitting in July, will be needed to assess accurately the effects of the freeze. It should, however, be recognized that the data for this study will of necessity be limited.

The Blue Cross and Blue Shield Association opposes a simple extension of the current fee freeze because we believe that it would have a negative effect on the new Medicare participating physician program, which promises substantial beneficiary protection. Physicians who entered into participating agreements did so with the understanding that they would receive specific future financial consideration because of their participation. We strongly urge you not to break that faith but to offer every feasible incentive to participate, including a financial incentive even if more limited than was provided in the Deficit Reduction Act of 1984.

We believe that the participating physician program and the claim-by-claim assignment option for other physicians should be continued for an additional period before any decision is made about eliminating or replacing it with an untried reform. It is our opinion, however, that the Medicare program should eventually eliminate the selective claim-by-claim option for physicians, and provide maximum incentives for physician participation. This policy, over time, offers the greatest potential to increase the

Medicare assignment rate because it takes full advantage of the changes that are occurring in the market for physicians' services. As the supply of physicians and beneficiary understanding of this simpler system increase, the market advantages of becoming a Medicare participating physician will likewise increase. Finally, this policy would better position Medicare to experiment with, and ultimately adopt some of the innovative cost containment approaches now being used by the private sector, such as preferred provider organizations and selective contracting. We recognize that no solution will be perfect, but believe that a strong participation policy will, on balance, be most advantageous to the program and its beneficiaries.

In conclusion, let me reiterate that we believe that a simple extension of the fee freeze would have negative effects on the new Medicare participating physician program. We strongly urge you not to renege on the government's commitment to provide incentives for physicians to participate.

STATEMENT OF ROGERS K. COLEMAN, M.D.

Dr. COLEMAN. Mr. Chairman, members of the committee, I want to first present the carrier's experience with the fee freeze.

During the enrollment period last summer, about 20.2 percent of Texas physicians signed participation agreements indicating their willingness to accept assignment on all Medicare claims, leaving 79.8 percent of physicians who chose not to participate.

The signup process and subsequent administration have been orderly and procedurally correct. There has been misunderstanding among beneficiaries and physicians alike, though.

In spite of the fee freeze, the assignment rate in Texas rose from 58.5 percent the month preceding the freeze to a current 64.4 percent.

To give you one other insight into that, for many, many years, up to about 2 years ago, the assignment rate in Texas vacillated between 49 percent and 52 percent, so there has been a significant rise in the assignment rate.

The Texas carrier was among the first in the Nation to notify physicians of apparent violations of the fee freeze provisions applicable to nonparticipating physicians. In the last quarter of 1984, comparing charges to those in the base period of April through June 1984, there were 3,640 physicians identified by the computer as having any rise at all in a fee, and of those, 346 were notified by letter that there was a problem we needed to discuss with them.

There was a 15-day turnaround time on the response, and we had 250 responses within three days after all the letters went out—rather remarkable response.

I think it is safe to say that not all of those physicians who have been identified or even all of those who got letters will wind up having clear violations of the physician fee freeze. That number will not be known for at least another month.

There are at least three options, as we see it, referable to the fee freeze in the upcoming debate on Medicare physician reimbursement.

The first one has been talked about already: continuing reimbursement profiles at the present level for another year. There would be no increase in part B payout, but in our opinion, this action would discourage physician participation.

The second option would be to keep nonparticipating physicians subject to the present reimbursement amounts, but let participating physicians have a profile update to a more current profile. In Texas at least, there would be a small increase in part B payout.

Another feature that needs to be brought to your attention is that maintaining more than one profile system to pay claims would require some administrative expense. I don't have a figure for that amount today but I can get that for you if you need it.

The third option would be to allow the freeze to end as designated in the Deficit Reduction Act, and the intricacies of the Medicare system would say that in Texas, you would have an increase in part B payout slightly higher than the inflation rate during calendar year 1983.

I would like to bring one final point referable to future considerations in physician reimbursement under the Medicare Program.

The physician is both a purchasing agent for medical services and a provider of care. The incentive and the opportunity for self-referral of practice income are present.

At the same time, the technological complexity of modern medicine renders the patient, and Medicare beneficiaries are patients, simply unable to make decisions on the medical necessity of services suggested by their physicians, or on the cost/benefit of those services. They do not have the necessary knowledge base.

For the patient, it becomes an economic decision: Can I pay for that service suggested by the doctor or are other means available to give me that service?

Somewhere in the future considerations, there needs to be a placing of the responsibility clearly on the physician, and an economic incentive, if possible, for him or her to take on the roles of purchasing agent, decisionmaker for medical necessity, and decisionmaker for cost/benefit concerns.

I am a physician and I have practiced 18 years and I am very sensitive to these kinds of things that are unique in the health care community.

Thank you.

[The prepared statement of Dr. Coleman follows:]

TESTIMONY

OF

BLUE CROSS AND BLUE SHIELD OF TEXAS

Mr. Chairman and members of the committee, I am Dr. Rogers Coleman, Associate Medical Director of Blue Cross and Blue Shield of Texas, the Medicare carrier for Texas. In addition, Blue Cross and Blue Shield of Texas serves as the Part A intermediary subcontractor to the Blue Cross and Blue Shield Association.

Thank you for this opportunity to comment, from the carrier point of view, on the effects of the physician fee freeze occasioned by the Deficit Reduction Act of 1984. This testimony will report on the early experiences of the Texas carrier in monitoring compliance by physicians with the freeze, and will offer some comments on future directions for Medicare in physician reimbursement.

Although it is not the topic of this hearing, I'd like to take this opportunity to congratulate the Congress on the legislation which changed Medicare hospital reimbursement from a retrospective, cost-based method to the present prospective payment system. In the state of Texas, there have been measureable and dramatic results thus far in reducing the wasteful use of resources in the care of Medicare and patients. These results have been accomplished without adverse effects on patient care.

With the success of the prospective payment system as a precedent, actions in regard to physician reimbursement have, as the saying goes, a tough act to follow.

Results of the Physician Fee Freeze in Texas

The Medicare physician fee freeze became effective July 1, 1984. There were two initiatives:

1. Reimbursement amounts for physician services were frozen at the Medicare fiscal year 1984 (FY 1984) level for the ensuing fifteen (15) month period, designated to end October 1, 1985.
2. All physicians were offered an opportunity to become Medicare "participating physicians." Those choosing to participate can increase their fees for the purpose of keeping their customary charge profile updated — but must accept the frozen Medicare allowable charge as their full reimbursement amount. Non-participating physicians are prohibited from raising fees to Medicare beneficiaries beyond those charged in the April — June quarter of 1984.

In Texas, 20.2% of the 24,000 physicians signed participation agreements; 79.8% are non-participating physicians. In spite of the low number of participating physicians who have agreed to accept assignment all of the time, the proportion of "Assigned Claims" received by the carrier has risen from 58.5% to 64.4%. At this point there are items worthy of emphasis:

1. relatively few physicians agreed to participate;
2. the proportion of assigned claims increased in spite of a freeze on Medicare reimbursement; and, as a result of this,
3. a larger proportion of beneficiaries are protected from higher out-of-pocket expenses.

Monitoring Activities of the Fee Freeze

Blue Cross and Blue Shield of Texas as the Medicare carrier was among the first in

the nation to give non-participating physicians written notice of possible violations of the fee freeze provision of the Deficit Reduction Act. The initial computer run comparing current charges to charges in the April through June base period identified three thousand six hundred and forty (3,640) physicians with what appeared to be unauthorized fee increases. In accordance with Health Care Financing Administration (HCFA) policy, cases involving total dollar increases of \$1,000 or more were pursued further. As a result, the top three hundred forty six (346) in the ranking order were notified between March 28 and April 15, with a request for a response. As of April 18, two hundred fifty (250) physicians had responded in writing.

At this point in our experience it can be confidently stated that not all of the potential cases identified will be in violation of the Deficit Reduction Act. Some represent coding errors; some are the result of actions taken by the carrier during claims processing. The actual number of real violations among those identified will not be known for another month.

We have received telephone calls and letters from beneficiaries which raise the question of whether some participating physicians are complying with the rules of the program. In some cases the participating physicians are allegedly refusing to accept assignment. Our claims processing system protects us from making a duplicate or erroneous payment in these cases, but each of these allegations is investigated fully. It will take considerable time to determine whether the physicians are violating the terms of their contract. Most of the cases have been attributable to a misunderstanding of the program. We have not seen any significant increase in utilization since the imposition of the fee freeze.

The Effect of the Fee Freeze on the Fiscal Year 1986 Physician Reimbursement

There are at least three scenarios which might be considered in regard to the future of the fee freeze:

1. The freeze is extended as is through the FY 1986 budget period;
2. the freeze is extended for non-participating physicians only; or
3. the freeze expires as originally designated on October 1, 1985.

Physician reimbursement under Part B of Medicare is complicated. It is also true that there is, in its original design and subsequent development, considerable evidence of genius. Given the requirements of a government program, to be predictable in terms of cost from year to year, procedurally defensible, and amenable to consistency in its administration, the Part B Medicare physician reimbursement system has served well its intended purposes. The complexity of Part B reimbursement is such that my comments on the three options will be general in nature and expressive of trends rather than specific numbers.

The freeze is extended as is through the FY 1986 budget period.

- o The level of payment would not change; the reimbursement profiles constructed from calendar year 1982 data will continue to be used to pay claims;
- o The net effect on Part B payout would be a decrease when compared to what spending would be under current law.
- o Beneficiaries would continue to be protected.

The freeze is extended for non-participating physicians only.

Under this option a decision would have to be made on how to update the profiles. The prevailing profiles could be updated by charge data from all physicians or just from participating physicians. Updating based on all charge data would result in lower average benefit payout because the increased charges of participating physicians would be averaged with the frozen charges of non-participating physicians. The other alternative of creating separate profiles would result in both higher benefit and administrative costs. It would, however, provide participating physicians with the greatest financial consideration and provide strong encouragement for other physicians to participate.

- o If separate profiles are constructed, utilizing the experience in Texas,
 - The profiles would not change for 79.8% of the physicians;
 - for 20% of the physicians the profiles would increase to some extent. A degree of control would occur by virtue of application of the updated Medicare economic index to limit rises in prevailing profiles;
- o There would be a substantial administrative expense to the carrier in creating and maintaining two different physician reimbursement profiles in the claims processing system, one for participating physicians and one for non-participating physicians.

The freeze is allowed to expire as designated on October 1, 1985.

- o Medicare Part B profiles would be updated using charges for services from April 1, 1984 through March 31, 1985;
- o Part B payout would increase according to the following contributions of data:
 - for the 79.8% non-participating contingent (where fees have been frozen), the increase would be based on actual charge increases from January 1, 1983, through June 30, 1984;
 - for the 20.2% participating physicians contingent, the increase would be based on actual charge increases from January 1, 1983 through March 31, 1985.

The end result of this mixing of charges would be subject to limitation by the Medicare Economic Index.

There is a final comment on the future of Medicare physician reimbursement. HCFA should have good suggestions for Congress in the report due July 1, 1985. If some method different from the present reimbursement system is chosen, it would be worthwhile to consider one unusual feature of the medical care system: the physician is both the purchasing agent for care and a provider of care. The opportunity and the incentive for self-referral to support practice income is present. Add to this the technological complexity of medical care. Most patients do not have a sufficient knowledge base on which to determine the necessity of services ordered or suggested, by the physician. From the patient's point of view, the decision is rarely one of medical necessity or of cost/benefit. It is one of whether the cost of the care can be covered. It is an economic decision from the patient's point of view.

In my opinion, putting the physician at risk in the reimbursement system for both the price and utilization of services places the medical necessity and cost/benefit decisions on the very knowledgeable physician purchasing agent.

The federal budget in an era of large annual deficits is a paramount concern, but it is not the only one. The task facing Congress is to solve this concern in a framework of maximum fairness to beneficiaries, to physicians, to hospitals, to private insurance premium payers, and to taxpayers.

Mr. WAXMAN. Thank you, gentlemen.

You are handling the payments for Medicare in Texas, so you have some knowledge about how this present freeze is working.

Are we saving money under the freeze?

Dr. COLEMAN. I don't know that we have measured that. I can get you a figure of the experience in Texas and provide it.

Mr. WAXMAN. I would like to have that information from you for Texas.

Are more doctors participating, which means taking assignment under all circumstances, than before?

Dr. COLEMAN. Mr. Chairman, we have not measured that. The measurement we do have is how many signed up this time.

Certainly if the participation part of the program continues, we will measure how many more or less sign up in the future, and that will be an accurate measure.

Mr. WAXMAN. Do you know whether we are seeing more of a volume of services or other kinds of ways for physicians to "game" the system or not go along with the expectations that at least the Federal Government had for them?

Dr. COLEMAN. We have a very sophisticated utilization review program in Texas, and in our opinion—and we can back it up, I think—there has been no gaming of the system in a widespread manner.

Mr. WAXMAN. You indicated only 20 percent of physicians in Texas signed up to be participating physicians.

Do you know why Texas is substantially lower than the national average?

Dr. COLEMAN. One reason would be that in many States, Blue Shield plans have established participating physician programs.

In Texas, we have never had a participating physician under any arrangement; it is prohibited under the Medical Practice Act. So we do not have participation with third-party payors other than Medicare, which supersedes the Act.

Mr. WAXMAN. Is it against State law to take the payment from an insurance company as full payment for treating patients under that company's plan?

Dr. COLEMAN. It is prohibited by State law, yes.

Mr. WAXMAN. Why?

Dr. COLEMAN. Good physician lobby.

Mr. WAXMAN. That is incredible.

Would it encourage physicians to sign participating agreements if we did not allow nonparticipating physicians to take assignment on a case-by-case basis?

Dr. COLEMAN. I believe it would.

Mr. WAXMAN. Why?

Dr. COLEMAN. Every physician has a contingent of patients that he is either going to choose to see for nothing or for what some third party is going to pay.

If he is prohibited from accepting what the third party is going to pay, he has to then make a decision to see them for nothing or to participate. Depending upon his neighborhood, he will have a large contingent of those kinds of patients or a small one.

I believe there will be a substantial number of physicians who are currently not participating who would shift over into the par-

ticipating ranks if the claim-by-claim assignment option were eliminated.

Mr. WAXMAN. Why wouldn't you expect physicians to shift the other way and not take those patients that he otherwise would take assignment for?

Dr. COLEMAN. I think that some will. I think the majority will move in the other direction.

Mr. WAXMAN. Why does it take so long to determine whether a physician is violating the freeze?

Dr. COLEMAN. They process involves a computer run which is the easy part of the process. Then you have to notify the physician, and look at individual claims where those higher charges appeared.

You have to review the action the carrier took in processing those claims, to see, for example, if we combined some charges that were submitted under one code number, that were originally submitted under two code numbers. It is a complex process to get down to the actual number of violators.

Mr. WAXMAN. Do you have any feeling as to whether it is a large number of violations or a small number?

Dr. COLEMAN. I have a feeling it is a small number.

Mr. WAXMAN. How many cases have you had of violations of the participating physician agreement?

Dr. COLEMAN. We have had a lot of complaints, Mr. Chairman, and to get that down to the actual number will be difficult for this reason: the chief confusion in Texas over the participation list lies in the fact that we have multiple provider numbers for different practice locations of physicians; a group practice over here, a hospital-affiliated practice over here.

In the hospital-affiliated practice, the physician may have chosen to participate, but in his group practice, he did not, so his name appears in the participation book, and yet the majority of his business is in the nonparticipating practice.

We have a lot of beneficiaries call us and say, "Dr. Jones is in the book but he didn't accept assignment on my claim."

That is the kind of confusions that causes our complaint level.

Mr. WAXMAN. If the physician freeze were extended, what do you think the effects would be on physician participation on the assignment rate and on beneficiary access?

Dr. COLEMAN. I personally don't think there will be any effect on beneficiary access early on. Long term, there surely will be.

Mr. WAXMAN. OK.

Dr. COLEMAN. If the freeze is extended, the obvious thought process of the participating physician is, "I have been wronged. I was promised at the end of this time I could have a profile update and now they are telling me I cannot."

There is still an advantage, however, and the advantage is that the physician can still register increased charges for use in future profile construction. The intricacies of how that is done will be important, and I am sure the Health Care Financing Administration realizes that.

I don't have a feel for what is going to happen to the participation rate if the freeze is extended for all physicians. It will not be as good as it would be, in my opinion, if you allowed participating

physicians to have a new profile and kept nonparticipating physicians at the current level.

Mr. WAXMAN. You don't think that would lead to more participating physicians?

Dr. COLEMAN. That latter scenario would, yes, sir.

Mr. WAXMAN. What would the effects be if we just ended the freeze, let it lapse?

In particular, what would the effect be on beneficiaries? Are they at risk of increased cost sharing from reasonable charge reductions on unassigned claims?

Dr. COLEMAN. Yes, sir.

Mr. WAXMAN. Dramatically?

Dr. COLEMAN. Yes, sir.

Mr. WAXMAN. Because of 1982 fees?

Dr. COLEMAN. Yes, sir.

Mr. WAXMAN. If we let the freeze end, the beneficiaries, where there is no assignment, are really going to get an enormous increase?

Dr. COLEMAN. I believe they would.

Mr. WAXMAN. Do you think there are fees that are out of line and could be reduced?

Dr. COLEMAN. There are fees that would not stand well the test of inherent reasonableness. How widespread that is, I am not sure, but that is the proper answer to your question.

Mr. WAXMAN. OK.

You mentioned there is an increase in the assignment rate overall.

Do you know how much of that increase in the assignment rate overall was due to the fact that Congress mandated for lab fees that there be an assignment, and how much was due to other kinds of fees other than those?

Dr. COLEMAN. The information I have that I presented to you as physician assignment rate is off of a report we get on physician claims, both participating and nonparticipating.

Mr. WAXMAN. Could that figure be affected by the fact that lab fees are now mandated by law for assignment?

Dr. COLEMAN. Those lab fees are not in those figures. Those are additional assignment rates.

Mr. WAXMAN. OK. Good.

Well, I appreciate this information very much.

Mr. Nielson, you may proceed.

Mr. NIELSON. I just have a couple of questions.

Dr. Coleman, are the physicians in your area complying with the fee freeze?

Dr. COLEMAN. Yes, sir.

Mr. NIELSON. What percentage are you having to monitor?

Dr. COLEMAN. We have 364 letters we sent out on 20,000 nonparticipating physicians, and I will guess that probably around a quarter of those have situations that will need to be monitored in the future.

Mr. NIELSON. About 25 percent of the nonparticipating?

Dr. COLEMAN. Twenty-five percent of 346 people that were notified will have to be monitored in my opinion.

Mr. NIELSON. Do you have any particular problems in communities with sole providers?

Dr. COLEMAN. I can't answer that because I don't know. We do have communities with sole providers, although in Texas there are very few.

Mr. NIELSON. How often are you contacted by beneficiaries who wanted to tell you their physicians increased their fees illegally and to find out whether their physicians are participating or not?

Dr. COLEMAN. We get about 1,000 calls a week.

Mr. NIELSON. In spite of the handy little booklet, you still get a lot of calls?

Dr. COLEMAN. Probably because of the little booklet. Because the physician agreed to participate in his hospital-based practice but not in his group practice, his name is in the book.

Mr. NIELSON. Does he have an asterisk then by his name? No explanation there?

Dr. COLEMAN. We don't have an explanation, that is right.

Mr. NIELSON. If I participate in 5 percent of my people and not with 95, I still get on the list, do I?

Dr. COLEMAN. Yes, sir.

Mr. NIELSON. All sorts of strategies you could develop to fool the public then?

Dr. COLEMAN. There are plans to correct that.

Mr. NIELSON. OK.

Are physicians confused about the new Medicare requirements mandated in the Deficit Reduction Act?

Many of them told me they are not accountants, not lawyers, but just plain, ordinary doctors. Do they get confused by all these regulations?

Dr. COLEMAN. Yes, sir.

Mr. NIELSON. Are they having to spend a lot of money on legal and accounting fees to make sure they are in compliance?

Dr. COLEMAN. I don't think so.

Mr. NIELSON. They are confused but they don't have to spend any extra money to take care of them?

Dr. COLEMAN. I don't think so.

Mr. NIELSON. To implement the physician fee freeze, how did you supplement this booklet to your participants and nonparticipants?

Dr. COLEMAN. Medical profiles are available upon request. We do require signature, but they are available to physicians. All they have to do is write us a letter; we will send it to them.

We are currently sending them the profile level that was in effect on June 30, 1984, that is the one that is in effect to pay claims today. They can get that information readily.

Mr. NIELSON. How would your fees, your profit picture, be changed, Blue Cross/Blue Shield, with the increase in participants?

If more participated than do now, would that increase or decrease the medical insurance cost?

Dr. COLEMAN. Talking about our private business?

Mr. NIELSON. Yes.

Dr. COLEMAN. Our private business does not have participating physicians. I think if we did, we could say safely that would improve our financial position.

Mr. NIELSON. Are you doing anything to encourage more people to participate on that basis?

Dr. COLEMAN. We do not have a lever to encourage people to participate.

Mr. NIELSON. If you were to communicate what you just told me, that that would lower the costs for the system altogether, wouldn't that help to get people to participate?

Dr. COLEMAN. In private business, I don't think it would currently.

Mr. NIELSON. I have an unrelated question, Mr. Chairman.

Mr. WAXMAN. If you will yield, in the State of Texas, there is a law against it. Even if they thought it made sense to participate, they are not permitted to do so.

Mr. NIELSON. Thank you.

I have a question related to Blue Cross/Blue Shield which is not directly related to copayment or anything of that nature.

There is a proposal to tax the fringe benefits of various employers, one of which is Blue Cross/Blue Shield protection.

Will you state for the record what that would do to employee-employer negotiations for such fringe benefits? How much would they have to increase their salaries to compensate for that tax, and what it would do to your insurance business as well?

It is key to people, not related to this subject.

Dr. COLEMAN. When you put a tax on premiums, you are going to hurt the insurance industry, without a doubt. People will opt to spend less money on premiums. That may involve squeezing down benefits, but the long-term effect on our insurance company, as I see it, would be some decrease in the amount of moneys available for us to pay claims and administer benefits.

Possibly that would give you a long-term effect of reducing the cost of health care.

The employer-employee negotiation is such that I personally feel the employer will transfer whatever expense he was spending on the now taxable insurance premium simply to a raise that will accommodate what was taken away.

Mr. NIELSON. It will open up all labor contracts. They have to be restudied because of that.

Dr. COLEMAN. That would be my opinion.

Mr. NIELSON. Would you concur that that would be devastating to the insurance business?

Dr. COLEMAN. Devastating is a hard word. It would cause problems.

Mr. SPIELMAN. The Blue Cross and Blue Shield Association strongly opposes the health care tax cap. We believe it is a sick tax and will hurt those most in need: the sick, the elderly, and those that are disabled.

We would be happy to submit for the record further explanations of those issues.

Mr. NIELSON. Thank you, Mr. Chairman. I know that is not part of our jurisdiction, but it is so closely related I thought I should ask that.

Mr. WAXMAN. Rather than submit it for the record, it would be helpful if you submitted it to Mr. Nielson.

Thank you, gentlemen, very much for your participation in this hearing.

Our third panel consists of two expert analysts in the field of physician payment, Paul Ginsburg, formerly of OMB, now with the Rand Corp., and Lynn Etheredge, formerly with CBO and now with the Urban Institute.

Mr. WAXMAN. Welcome to our hearing today, gentlemen. Your statements will be part of the record in full.

Mr. Ginsburg.

**STATEMENTS OF PAUL B. GINSBURG, SANTA MONICA, CA.; AND
LYNN ETHEREDGE, SENIOR RESEARCH ASSOCIATE, THE
URBAN INSTITUTE**

Mr. GINSBURG. I am very pleased to be here, Mr. Chairman.

I am speaking today on my own behalf and not representing the Rand Corporation or its research sponsors.

The key finding from research analyzing the supplementary medical insurance program outlays is the role of increasing volume of services, principally procedures as opposed to visits.

In the long term, control of costs in this program requires changing physician incentives to prescribe services by using a unit of payment that is broader than the service that is used today.

Also, we need to increase the market power of Medicare and its beneficiaries in the physician area, so that reimbursement cuts and new incentives do not unduly burden the beneficiaries.

Congress has taken some very important steps in these directions over the past four years. I think particularly significant has been the 1982 legislation authorizing payment of HMO's on a capitation basis—legislation that originated in this committee.

Also the hospital prospective payment system has indirect but very important effects on physician service use. And finally, the participating physician concept enacted last year is also a very important long-term step in this direction.

Two physician payment options beyond what Congress has already done have been getting extensive attention; physician DRG's and fee schedules that change relative values. The first is too risky to consider implementing at this time, while the second does not get at the incentives of the fee for service system.

The physician DRG option has the potential of saving resources through the incentives of a broader payment unit, and if the payment went to the attending physician would induce some badly needed price competition among non-attending physicians.

But the large variation of resource needs across patients in a DRG, especially in cases other than surgery, could lead to major financial risks to both those physicians treating those patients with high needs relative to others in a DRG and the patients themselves.

Costly patients could find themselves either with a large out-of-pocket liability for the difference between fee-for-service charges and the DRG payments, or with limitations in access to participating physicians attempting to avoid an unprofitable case.

Without changes in assignment policy, a physician DRG system could turn out to be a beneficiary DRG system, with all the DRG incentives being placed on the beneficiaries rather than on physicians.

The virtual absence of private sector or foreign medical system experience with this type of patient also argues against implementation at this point, although a well-designed demonstration begun soon could be very useful.

Fee schedule options are much more practical at this point, but their potential to achieve a reduction in the volume of services is uncertain.

While I agree with those who conclude that we are paying too much for procedures relative to cognitive services, little research is available to tell us what the effects of the change in relative fees would be on the volume and mix of services.

While the risks of a fee schedule are much smaller than those of physician DRG's, we could wind up expending a great deal of effort to achieve little but some redistribution of income among physicians. A demonstration of this option, possibly coupled with the one on physician DRG's, would increase knowledge in this area as well.

The Congress faces a particularly difficult problem in formulating Medicare policy this year. Over the past 4 years it has passed a tremendous amount of important legislation, both putting in place some fundamental program reforms and reducing program outlays by a substantial amount.

While the savings from these measures will continue and indeed grow in future years, what has been achieved is incorporated into the baseline budget projections and projected deficits are still way too large.

Thus, if additional domestic spending cuts are to play a role in reducing the deficit, the Congress will again have to turn its attention to Medicare, but this time without major reforms that are ready for implementation.

The President's proposal for extension of the freeze is a particular disappointment. The original freeze had been billed as a stop-gap we do not seem any closer to its replacement with a policy that has more merits.

Rather than a general extension of the freeze, I propose a more selective strategy with actual reductions in reasonable screens for selected procedures whose fees appear to be out of line with those for other physician services.

By concentrating on relatively overpriced procedures, the increased burden on beneficiaries might be less than an equivalent reimbursement reduction achieved through a general freeze. Important steps would have been taken toward a more rational pattern of relative reimbursements.

Procedures introduced within the last 10 or 15 years are the best candidates for such an approach. When procedures come into use, Medicare fee screens automatically reflect the fees of the pioneering physicians. As experiences with the procedures and additional technological developments reduce the time and skill required, and a broader segment of physicians perform it, the relative fee should fall. But this tends not to occur. Examples of such procedures in-

clude cataract surgery, coronary artery bypass surgery, colonoscopy and upper GI endoscopy.

By concentrating reimbursement cuts on procedures that are overpriced, beneficiaries might be in a better position to avoid additional liability. While the research is especially scanty in this area, the reasoning is that even after reductions in the screens of 10 or 20 percent, such procedures would still be highly profitable. Thus, as long as enough beneficiaries took account of the difference in out-of-pocket liability between assigned and unassigned claims, competition would lead to continued availability of such services on an assigned basis.

Assignment could also be encouraged by focusing on procedures performed by physicians that the beneficiary chooses, like surgeons, rather than those where the beneficiary has little say, such as radiologists and pathologists.

I have given some thought to how such an approach might be pursued. Most promising would be the use of panels of experts within closely related specialties that would develop lists of procedures to be singled out for reimbursement reductions, and recommend specific reductions.

Panels would identify a procedure as overpriced through comparison with more established procedures, using criteria such as length of time, relative skill, amount of training, and risk. The reimbursement for each overpriced procedure would then be specified relative to that for a more established procedure.

For example, the reimbursement for colonoscopy might be set as a multiple of that for sigmoidoscopy. Each carrier would then revise its prevailing screens for the overpriced procedures so that they are based on screens for specific established procedures. If such an approach were enacted this summer, the reductions could be incorporated in screens by October 1, 1986, or possibly earlier.

If such a measure were pursued as part of budget-cutting legislation, the Congress would have to spell out to the Health Care Financing Administration the degree of activity to pursue. Congress could specify that reimbursement reductions not be less than those that would have been achieved with a freeze, or some other criterion. Alternatively, it could specify only that procedures accounting for a certain percentage of reimbursements be reviewed.

In order to speed implementation, the Congress could pursue a more broadly focused version of this approach. For example, there is evidence that inpatient physician services are more highly reimbursed than outpatient services, and that surgery is paid more than medical services. The Congress could limit a freeze to, or reduce reimbursements somewhat for, inpatient services and outpatient surgery. This broader focus would not achieve as much as a procedure-specific one in terms of attempts to minimize shifts of the burden to the beneficiaries. Perhaps the broader approach could be temporary, to be supplanted with the procedure-specific approach 1 year later.

Not all of the budget objective should be met by reimbursement cuts, however. While the approach that I have suggested might reduce the burden on low-income beneficiaries, it would not eliminate it. Premium or tax increases aimed at high-income beneficiaries should play a role in meeting budget objectives. A number of

options to accomplish this are feasible. One would treat the Government's contribution to SMI as taxable income. Low-income beneficiaries would not be affected. Alternatively, the SMI premium could be pegged at a higher percentage of program outlays for those with incomes above a certain threshold.

In conclusion, this is a difficult year, in that there is pressure to reduce the size of the appropriation for SMI, but shortrun options to encourage structural reform are limited. Rather than simply extend the freeze for another year, the Congress should concentrate reimbursement cuts on those procedures judged to be relatively overpriced, and ask higher income beneficiaries to bear more of the burden of growth in the cost of this program.

[The prepared statement of Mr. Ginsburg follows:]

STATEMENT OF

Paul B. Ginsburg

Mr. Chairman, I am pleased to be here today to discuss the reimbursement of physicians in the Medicare program. I am appearing on my own behalf, and am not representing The Rand Corporation or its research sponsors, or reporting on Rand research.

My statement will indicate that the Congress has already taken some critical steps towards long-term reform of physician payment in the Medicare program, but is now faced with the task of saving money during an interim period before its reforms can affect the bottom line. To meet budget objectives during this interim period, reimbursement cuts should focus on those services that are relatively overpriced, and higher-income beneficiaries should be asked to shoulder more of the burden.

BACKGROUND

The rapid increase in physician charges under the Supplementary Medical Insurance program (SMI) has been a burden to taxpayers and beneficiaries alike. Appropriations from general revenues to the SMI Trust Fund increased from \$2.3 billion in 1975 to \$16.9 billion projected for the current fiscal year. Outlays will have doubled as a percentage of federal domestic spending. While percentage increases in the monthly premiums paid by beneficiaries were, until 1983, limited to increases in Social Security benefits, beneficiary liability for charges exceeding screens for "reasonableness" also has increased substantially. In 1983, the average unassigned claim was reduced by 23.1 percent, compared to 16.6 percent in 1975.

Analysis of growth in SMI reimbursements to physicians over this period shows that rising increases in services per enrollee are a very important component. Over the 1975-1983 period, enrollment grew at 2.3 percent per year, reimbursements per service at 8.5 percent, and a services per enrollee at 6.9 percent.¹ The last factor, associated with changes in medical practice, includes more services billed per visit, increased use of expensive new procedures, and other factors.

¹David Juba, The Urban Institute.

Significant reductions in SMI outlays that do not represent shifts of responsibility to the beneficiaries will require both a slowing of this volume factor and increased use by Medicare and its beneficiaries of their potential market power. To slow the volume factor, we must change the incentives that we give physicians, from those of fee-for-service payment, which encourages increased provision of services, to those of broader units of payment, such as episodes of illness, or annual per enrollee amounts. To increase the use of market power, we must give consumers more information and restrict the ability of providers to make case-by-case decisions on accepting assignment.

RECENT LEGISLATION

The Congress has already taken important steps in these directions. Probably most important for SMI in the long run is Section 114 of the Tax Equity and Fiscal Responsibility Act of 1982, which authorizes reimbursement on a capitation basis to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs). This will increase access by the Medicare population to types of organizations that have demonstrated the ability to contain costs through a lower rate of use of services, particularly inpatient hospital services. I expect that substantial numbers of beneficiaries will enroll in HMOs and CMPs under this authority.

In the course of recent research on employee health plans in the private sector, I have gained particular appreciation for two provisions of Section 114. The first requires HMOs to either reduce beneficiary premiums or provide additional services when the adjusted community rate is lower than the Medicare reimbursement payment. Many employers suspect that much of the cost savings achieved by HMOs are not being passed on to them or their employees, but have few tools to change this. The Medicare provision ensures that cost savings are passed on to the beneficiaries.

The second provision is the use of adjustments for age, sex, and geographic location in the setting of payment rates to HMOs. While the adjustments can stand some technical refinements, they go much further than the private sector has in limiting the problems associated with

those enrolling in HMOs having expected costs that differ from the average.

While many beneficiaries will save money on medical care as a result of Section 114, it will be many years before the federal government realizes a significant reduction in outlays. Initially, those beneficiaries enrolling in HMOs are likely to have had lower costs than their peers who continue in the fee-for-service system upon whose experience the rates are based. With future refinements in the mechanisms used to set Medicare's payment rates and new enrollees becoming a smaller percentage of Medicare beneficiaries in HMOs, this phenomenon is likely to diminish over time.

A more fundamental obstacle to significant reductions in outlays is the fact that Medicare payments to HMOs and CMPs are based on the program's experience in the fee-for-service sector. This basis is appropriate now, since it is important to give beneficiaries substantial incentives to enroll in alternative plans. But important program savings await the point where a large enough proportion of beneficiaries are enrolled in HMOs or CMPs that the Congress decides to base its payments on costs of care in these types of organizations and asks those beneficiaries deciding to continue in the more expensive fee-for-service system to pay more.

The prospective payment system for hospitals that was enacted as part of the Social Security Amendments of 1983 will also contribute to a slowing of the volume of services paid for by SMI. While the legislation does not affect physician services directly, the incentives to hospitals to reduce length of stay and the use of X-rays and laboratory procedures will in turn reduce the volume of physician services delivered in the course of the hospital stay. Prospective payment for hospital care may be an important factor behind the fiscal year 1984 increase in SMI outlays amounting to only 11.2 percent, compared to a 17.7 percent increase in 1983 when general inflation was similar.

Finally, the provision of the Deficit Reduction Act of 1984, establishing the concept of a "participating physician" who agrees in advance to accept assignment for all Medicare claims, will work to limit the out-of-pocket burden on beneficiaries. By assisting beneficiaries

in choosing physicians who will accept assignment, this provision will increase the assignment rate by beginning to harness the program's potential market power. With the growing supply of physicians, this is the right time to embark in this direction.

ADDITIONAL LONG-TERM STEPS

Two physician payment options beyond what the Congress has already done have been getting extensive discussion--physician DRGs and fee schedules. The first is too risky to consider implementing at this time while the second, though useful, does not get at the major problem in physician payment--the incentives of the fee-for-service system.

The physician DRG option would extend Medicare's per discharge payments to inpatient physician services. This option has the potential of saving resources through the incentives of a broader payment unit and, if the DRG payment went to the attending physician, would induce some badly-needed price competition among nonattending physicians. But the large variation of resource needs across patients in a DRG, especially in cases other than surgery, could lead to major financial risks to both the physicians treating those patients with high needs relative to others in a DRG and the patients themselves. Costly patients could find themselves either with a large out-of-pocket liability for the difference between fee-for-service charges and the DRG payment or with limitations in access to participating physicians attempting to avoid an unprofitable case. The virtual absence of private sector or foreign medical system experience with this type of payment also argues against implementation at this point, although a well-designed demonstration could be very useful.

Fee schedule options are much more practical at this point, but their potential to induce a reduction in the volume of services is uncertain. While I agree with those who conclude that we are paying too much for procedures relative to "cognitive" services, little research is available to tell us what the effects of a change in relative fees would be on the volume and mix of services. While the risks of fee schedules are much smaller than those of physician DRGs, we could wind up expending a great deal of effort to achieve few intended results. A demonstration of this option, possibly coupled with one on physician DRGs, will increase knowledge in this area as well.

SHORT-TERM MEASURES

The Congress faces a particularly difficult problem in formulating Medicare policy this year. Over the past four years it has passed a tremendous amount of important legislation, both putting in place some fundamental program reforms and reducing program outlays by a substantial amount. While the savings from these measures will continue and indeed grow in future years, what has been achieved has been incorporated into the baseline budget projections, and the projected deficits are still way too large. Thus if additional domestic spending cuts are to play an important role in reducing the deficit, the Congress will again have to turn its attention to Medicare, but this time without major reforms that are ready for implementation.

The President in his Fiscal Year 1986 Budget proposed an extension in the 15-month freeze in physician reimbursements and an increase in the proportion of SMI outlays that is supported by beneficiary premiums. The proposal for an extension of the freeze is a particular disappointment, since the original freeze had been billed as a stop gap, but we do not seem any closer to its replacement with a policy that has more merits. I am concerned that the gap between what physicians get for treating privately-insured patients and what they get when they accept assignment for Medicare patients not grow further, but an additional year of a general freeze could have a substantial effect on this.

Rather than a general extension of a freeze, I propose a more selective strategy, with actual reductions in reasonable screens for selected procedures whose fees appear to be out of line with those for other physician services. By concentrating on relatively overpriced procedures, the increased burden on beneficiaries might be less than an equivalent reimbursement reduction achieved through a general freeze, and important steps would be taken towards a more rational pattern of relative reimbursements.

Procedures introduced within the last 10 or 15 years are the best candidates for such an approach. When procedures came into use, Medicare fee screens automatically reflect the fees of the pioneering physicians. As experience with the procedure and additional

technological developments reduce the time and skill required, and a broader segment of physicians perform the procedure, the relative fee should fall, but this tends not to occur. Examples include cataract surgery, coronary artery bypass surgery, colonoscopy, and upper G.I. endoscopy.

By concentrating reimbursement cuts on procedures that are overpriced, beneficiaries might be in a better position to avoid additional liability. While the research is especially scanty in this area, the reasoning is that even after reductions in the screens of 10 or 20 percent, procedures of this type would still be highly profitable. Thus, as long as enough beneficiaries took account of the difference in out-of-pocket liability between assigned and unassigned claims, competition would lead to continued availability of such services on an assigned basis. Assignment could also be encouraged by focusing on procedures performed by physicians that the beneficiary chooses, like surgeons, rather than those where the beneficiary has little say, such as radiologists and pathologists.

I have given some thought to how such an approach might be pursued. Most promising would be the use of panels of experts within closely related specialties that would develop lists of procedures to be singled out for reimbursement reductions, and recommend specific reductions. Panels would identify a procedure as overpriced through comparison with more established procedures, using criteria such as length of time, relative skill, amount of training, and risk. The reimbursement for each overpriced procedure would then be specified relative to that for a more established procedure. For example, the reimbursement for colonoscopy might be set as a multiple of that for sigmoidoscopy. Each carrier would then revise its prevailing screens for the overpriced procedures so that they are based on screens for specific established procedures. If such an approach were enacted this summer, the reductions could be incorporated in screens by October 1, 1986 or possibly earlier.

If such a measure is pursued as part of budget-cutting legislation, the Congress will have to spell out to the Health Care Financing Administration the degree of activity to pursue. Congress could specify that reimbursement reductions not be less than those that would have

been achieved with a freeze or some other criterion. Alternatively, it could specify only that procedures accounting for a certain percentage of reimbursements be reviewed.

In order to speed implementation, the Congress could pursue a more broadly focused version of this approach. For example, there is evidence that inpatient physician services are more highly reimbursed than outpatient services, and that surgery is paid more than medical services. The Congress could limit a freeze to (or reduce reimbursements somewhat for) inpatient services and outpatient surgery. This broader focus would not achieve as much as a procedure-specific one in terms of attempts to minimize shifts of the burden to the beneficiaries. Perhaps the broader approach could be temporary, to be supplanted with the procedure-specific approach one year later.

Not all of the budget objective should be met by reimbursement cuts, however. While the approach that I have suggested might reduce the burden on low-income beneficiaries, it cannot eliminate it. Premium or tax increases aimed at high-income beneficiaries should play a role in meeting budget objectives. A number of options to accomplish this are feasible. One would treat the government's contribution to SMI as taxable income. Low-income beneficiaries would not be affected. Alternatively, the SMI premium could be pegged at a higher percentage of program outlays for those with incomes above a certain threshold.

CONCLUSION

In conclusion, this is a difficult year, in that there is pressure to reduce the size of the appropriation for SMI, but short-run options to encourage structural reform are limited. Rather than simply extend the freeze for another year, the Congress should concentrate reimbursement cuts on those procedures judged to be relatively overpriced, and ask higher-income beneficiaries to bear more of the burden of growth in the cost of this program.

Mr. WAXMAN. Thank you very much, Mr. Ginsburg.
Mr. Etheredge.

STATEMENT OF LYNN ETHEREDGE

Mr. ETHEREDGE. Mr. Chairman, the major issue before this committee today—how Medicare ought to pay for physicians services and protect its beneficiaries from overcharging—is a very important one. In my view, some high priority exceptions should be allowed to an across-the-board freeze in fiscal year 1986. Some fees should be allowed to increase, other fees should be reduced, and assignment should be expanded.

These are reforms consistent with the policy directions established by this committee and the Congress last year.

If I may, I will briefly summarize the four major points covered in the written testimony.

In terms of fee increases, I believe the highest priority for fee increases should be office, nursing home, and home visits provided by participating physicians.

This action would start to correct the underpayment of these out-of-hospital services compared to surgery and other inpatient care. It is essential to maintain and expand the participating physician program which is an important protection for Medicare beneficiaries. Finally, these adjustments would recognize the billions of dollars which physicians have already saved the Medicare Program through reducing Medicare hospital use and slowing the rate of growth of extra services in the part B program.

If funds are available, I believe the second reform priority for increasing fees would allow other customary fees by all participating physicians to increase at least up to the average customary charge. But first priority should go to the basic office, home, and nursing home visit.

In terms of fee reductions, there is strong evidence that the Medicare Program is paying more than it needs to for high priced surgical procedures, specialty services, and high volume increase procedures. For surgery, it is useful to look at the Hsaio and Stason study which shows surgical procedures paid at four to five times the rate of office-based care, and it is also useful to look at what has been achieved in Canada where rates are set by negotiation rather than by open-ended CPR methods.

For example, Medicare's average prevailing charge for hysterectomy was \$1,009 in 1984; in Ontario the fee was \$503. Medicare paid \$988 for extraction of a lens; in Ontario physicians received \$368.

The second area of overpricing is specialty designation. Medicare allows any physician who wants to to declare himself a specialist and seek higher payment. Nearly half of all self-declared physicians are not board certified in that specialty. This needs to be tightened up by limiting the specialty payment to physicians who are, in fact, board certified.

The third area for review and possible adjustment in fees is high volume increase services. These are services for which the reason for the increase may be the profits involved rather than medical criteria. Office-based EKG's are one example. Medicare pays \$40

for the test; in Ontario, with negotiated fees, charges are \$7. A number of these types of fees need to be examined.

The final area that needs to be looked at is assignment. I suggest mandatory assignment for inpatient surgery as well as assistants at surgery, inpatient anesthesiology, radiology, and pathology. I see no evidence that market forces are able to restrain fees in these areas, because of high rates of insurance coverage.

In 1981 to 1983, for example—the worst economic conditions in the past 50 years—surgical incomes rose 23 percent to \$145,000.

As well, the average extra charge on unassigned surgical bills runs about \$100, compared to \$5 for medical bills. So requiring assignment on these services would be a major step toward protecting the Medicare beneficiary.

Finally, I believe that both Congress and HHS would be assisted in these efforts by establishing a Physician Payment Assessment Commission in parallel with the Prospective Payment Assessment Commission for hospital payments. This commission could be asked to report by April of next year on specific fee reductions which could be made by the end of fiscal year 1986, on how to expand the participating physician program and assignment and on specialty designation issues.

Thank you.

[Testimony resumes on p. 637.]

[The prepared statement of Mr. Etheredge follows:]

Testimony of
Mr. Lynn Etheredge
The Urban Institute

Mr. Chairman and Members of the Committee:

My name is Lynn Etheredge. Currently, I am a senior research associate at The Urban Institute here in Washington. My previous experience includes more than ten years of policy research on government health care financing programs, including service from 1978-1982 as chief of the health branch at the Office of Management and Budget.

The issues now being considered by this Committee--how Medicare should pay for physicians services and protect its beneficiaries--involve a re-examination of fundamental policies established with Medicare's enactment twenty years ago. The Congress started reform of these policies last year when it enacted a freeze on physician payment rates, established a new "participating physician" program, and requested studies of several major reform issues. As I understand the major issue today, it is whether simply to extend the freeze, pending receipt of requested studies, or to continue the reform process this year.

There are two principal reasons why I believe Congress should take further steps to reform Medicare physician payment policies for FY 1986:

--First, an across-the-board freeze would fail to recognize physicians' cooperation in changing their patterns of medical practice to treat patients in less expensive, non-hospital settings, which has produced several billions of dollars of savings in the hospital insurance program, and physicians' willingness to assist Medicare's beneficiaries by signing up for the participating physician program. By allowing higher payments for selected services and providers, the Medicare program can respond to such developments and also encourage continuation of these trends.

--Second, there are high priority reforms needed where the Medicare program is overpaying for what it is purchasing and distorting the practice of

medical care toward unnecessary services and overuse of hospital-based services. There are also opportunities for new assignment policies to expand financial protection of Medicare beneficiaries. It is timely and important to pursue policy changes in these areas as rapidly as possible.

I. Potential Medicare Fee Increases

Selective Medicare physician fee increases in FY 1986, as an alternative to an across-the-board extension of the current freeze, would be warranted, in my view, for office, nursing home and home health visits, and for participating physicians' services.

The Medicare CPR reimbursement methods have considerably undervalued non-hospital visit rates, compared to surgical (and other inpatient) procedures. A study by Hsaio and Stason, for example, found that office-based care has been paid at hourly rates of only one-fourth to one-fifth the hourly rate for surgical procedures, even after adjusting for different periods of training and other cost-related factors.¹ As well, Medicare's prevailing charge payments for hospital visits averaged 18-32 percent higher than for office visits in 1982.² Taking into account both the higher per visit payment for hospital care and the possibility of physicians seeing more patients per hour in a hospital setting than in the office, Blumberg has estimated internists generate nearly twice as much income per hour from hospital care as from office practice.³ Such payment discrepancies are strongly reflected in physicians' incomes. From 1981-83, for example, AMA data show net practice incomes of general practitioners and family physicians fell from \$72,200 to \$68,500, while surgery specialists increased their net revenues by 23 percent, from \$118,600 to \$145,500.⁴ A continued across-the-board freeze would continue these income differentials for surgical and other in-hospital care, thus perpetuating the biases in current payment rates toward expensive hospitalization of patients.

In contrast, a higher rate of increase in Medicare fees for office, nursing home, and home visits than for surgical and other inpatient services in FY 1986 would begin to address these fundamental problems.

During the past two years, there have been extraordinary economies achieved in the Medicare hospital insurance program as a result of declining hospital admission rates--a reversal of previous trends--and sharp reductions in the average length of stay. The 1985 HI Trustees Report estimates an admissions/enrollee decline of 3.1 percent occurred in 1984 compared to annual increases for the previous five years. As well, the 1985 SMI Trustees Report estimates that annual rates of volume and service-mix increases in physicians' services per elderly enrollee also slowed dramatically, from 10.8 percent in 1983 to 3.2 percent in 1984.

There is not yet very good evidence about all of the factors which may have been involved in these developments. Most observers would agree, however, that the medical decisions involved in producing the savings--whether or not to admit a patient to a hospital, when a patient may safely be discharged, what tests and other procedures should be employed--all lie within the realm of physician decisions. Thus it seems probable that physicians have taken actions, counter to their own economic self-interest, to assist in dealing with rising health care costs. As well, by assuming greater responsibilities in their non-hospital practices, these physicians likely increased the difficulty of their work in these settings, e.g., conservatively managing more patients whose illness could have justified hospitalization. A sharing of some part of the federal savings would thus seem to be warranted now in recognition of these recent developments, as well as because such increases in relative payments for non-hospital care are desirable reform objectives in themselves.

A second priority exception to a Medicare physician fee freeze should be considered for participating physicians. By agreeing to accept assignment on all Medicare claims, participating physicians not only forego income, which many of their colleagues are collecting, but also protect Medicare beneficiaries. In 1982, for example, the average unassigned bill was 32 percent greater than what Medicare recognized for payment, so the savings from assignment for beneficiaries is substantial. As well, the "participating physician" program enacted last year clearly indicated an intention to provide higher fee increases for participating physicians than to their non-participating colleagues. To maintain the credibility of the program--and to encourage future growth in the number of participating physicians, which will assist the elderly--it thus seems desirable for Congress to target fee increases to these physicians.

These two general priorities for exceptions to the Medicare physician fee freeze--office/nursing home/home health visits and participating providers--suggest that first claim for additional funds should belong to services which meet both criteria, i.e., unfreezing customary charges by participating physicians for office, nursing home and home health visits. Such reforms would be a substantial step in furthering policy reforms already initiated by Congress to reduce unnecessary hospitalization (DRGs) and encourage more participating physicians.

It is substantially more difficult to suggest other exceptions to the freeze which would clearly be consistent with longer range reforms. An across-the-board fee increase for all participating physicians, for example, could result in raising some charges which are already too high. If we can make the assumption, however, that most future fee reforms, (e.g., a fee schedule or physicians DRGs) would likely be developed on the basis of current

average charges, then a second priority for exception to the freeze might be allowed for updating of customary charges by participating physicians which are now below the average customary charge for such services. Such a policy would develop greater uniformity in fees, move toward an average-charge based fee schedule, and also recognize those physicians whose below-average charges and assignment agreements have done most to offer economical health care services for the Medicare beneficiary.

If combined, these two measures would allow (1) a full updating of all customary charges by participating physicians for office, nursing home and home health visits which are below the prevailing charge limits; and (2) an updating for all other customary charges by participating physicians which are below the average customary charge.

II. Potential Medicare Fee Reductions

While there are some Medicare fees which should be allowed to increase as an exception to the freeze, there are also several areas where current evidence suggests that twenty years of open-ended CPR reimbursement policies result in Medicare paying too much for services. Several of these priority areas for policy review are discussed below. Establishment of a Physician Payment Assessment Commission is also suggested to develop specific recommendations for the Secretary of HHS and Congress in setting the new fees.

Three areas which evidence suggests be targeted for such reviews are surgical procedures, specialty designation, and high volume increase services.

--Surgical procedures. Several studies, such as those cited earlier, indicate that surgical services are now overpaid compared to other physician services. As well, Dr. Benson Roe, a distinguished surgeon, testified before this committee two years ago about the overpayment of surgery by UCR-type reimbursement (including Medicare), with particular reference to coronary

artery bypass surgery. With Medicare CPR reimbursement methods, a fee for a new service, such as bypass surgery once was, is established when it first becomes part of accepted medical practice and may still be expensive and difficult. Nevertheless, the CPR method continues to recognize such fees--and fee increases--even as a procedure becomes routinized and costs fall with experience and volume. Coronary artery bypass surgery, for example, was a procedure initially recognized for payment when lack of experience with the procedure required exceptional time commitment by the surgeon, including diagnosis and post-operative care. Dr. Roe noted that a skilled surgeon could now perform 3-4 such operations per day.

The following table (Table 1) shows the highest national prevailing charges now paid by the Medicare program, taken from reports for the 110 most common procedures. All of these charges are for surgical services, and may require only a few hours of time (or less) by a highly skilled, practiced surgeon. A review of prevailing charge reports shows that the highest national figures range about 70 percent greater than these averages. (The Medicare program's prevailing fee for bypass surgery in New York City, for example, was \$5890 in 1983). For contrast to these Medicare prices, surgical fees in Ontario--which are set through negotiations with physicians rather than by CPR methods--were \$503 for hysterectomy, \$368 for lens extraction, and \$334 for insertion of a pacemaker in 1984.⁵ It thus seems sensible to start a review of surgical fees generally with these highest price services.

A special review priority also ought to be given to what Medicare is paying for expensive surgical procedures for which it is by far the most important payer. In these instances, there is little non-Medicare business to prevent customary fees from escalating to the maximum allowed by Medicare's CPR system. Based on National Center for Health Statistics (NCHS) data,

Table 1
Medicare Prevailing Charges, 1984

<u>Procedure</u>	<u>National Average</u>
Coronary artery bypass	\$3964
Replacement of hip	2505
Open reduction of fracture	1357
Partial colectomy	1265
Prostatectomy	1173
Insertion of pacemaker	1125
Radical mastectomy	1041
Electrosection prostate	1010
Hysterectomy	1009
Extraction of lens	988

surgical procedures for which the Medicare program has more than a 75 percent "market share" include extraction of lens, insertion of prosthetic lens, insertion of pacemaker, prostatectomy, and hip replacement. Is it just a coincidence that all of these procedures also appear on the list of the highest price services in table 1? The similarities suggest that, if one were to look for excessive Medicare payment rates, expensive surgical procedures should rank high on the review list.

If the Congress does consider reducing surgical procedure fees, there may be questions about whether such a policy would significantly affect the availability of such services. Although there may be exceptional cases (which should be left to be handled by Secretarial discretion), national studies--such as the GMENAC report--suggest that surgeons are in excess supply. As well, the American Medical Association's data show that surgical specialists (general surgery, neurosurgery, ophthalmology, orthopedic surgery, plastic surgery, colon and rectal surgery, thoracic surgery, urology) now average 13.2 hours in surgery per week. The range among census regions was from 11.6 hours in the Pacific region to 14.5 hours in the East North Central region. In non-metropolitan areas, surgical specialists averaged 13.8 hours of surgery, while colleagues in metropolitan areas over 1,000,000 population averaged 12.7 hours.

--Specialty designation. The Medicare program is also likely overpaying for services as a result of its policies on specialty designation and payments. The Medicare program now leaves the determination of whether or not a physician is a specialist--and thus eligible to be paid more than a "non-specialist" for providing the same service--mostly to self-declaration, with carrier-level review. Thus the current policies are neither uniform nationally, nor do they restrict a "specialty" designation simply to individuals who have met generally recognized criteria to be designated as specialists. AMA

studies indicate, for example, that 48.7 percent of non-federal self-declared physician specialists were not board-certified in that specialty. A recent GAO report has also discussed these issues. Specialty designation results in added costs to the Medicare program, e.g., prevailing charges for specialists visits were 19 to 53 percent higher than for nonspecialist visits in 1982.

When considering longer run reforms, Congress will want to reconsider the issue of whether any specialty differences are justified. An interim reform in this area, however, would limit specialty designation (and payment) to those physicians who are board-certified in their specialty by the appropriate accrediting board. Physicians who did not meet these criteria would be subject to the prevailing charge screens which apply to non-specialists. Since some physicians may truly be specialists but have never obtained the formal credentials, it may be appropriate to implement this policy as of some date in the future, e.g., January 1, 1986, so that such physicians who desire to obtain formal credentials could do so.

--High volume increase services. Review and possible adjustment of current fees should also be considered for services which show the highest rate of volume increase. These services should be targeted for review because of the possibility that such unusually high rates of change result from Medicare prices which are too high, resulting in excess profit rates. In particular, various "add-on" tests and procedures, many of which can be performed in the physicians' office, appear to offer an opportunity for unnecessary revenue generation. In reviewing HCFA data which are submitted for prevailing charge reports, for example, office-based EKGs seem to be a leading example of the type of service for which examination of the price level would be appropriate.⁶ The test is simple, not dangerous or particularly uncomfortable for the patient, is unlikely to be questioned for an elderly patient--and involves

very little physician cost once the machinery has been purchased. The Medicare prevailing charge for the test was \$40 in 1984; in Ontario, with negotiated rates, a physician would have been paid \$7.

Over the 1977-82 period, the volume of EKG interpretation fees paid for by the Medicare program per aged enrollee increased by 75 percent. Studies of the Cost of Living Council period, using California data, have also shown that EKGs were among the most rapidly rising Medicare services--more than 30 percent--over the 1972-74 period in which physicians used service volume increases to more than offset fee restraints of wage and price controls.⁷ Other procedures with rapid rates of increase over the 1977-82 period include arthrocentesis, skin biopsy, and CT scans. As well, prevailing charges for consultations--which increased much more rapidly than office and hospital visits over the period--average more than three times the office and hospital visit rates, so a review of the relative fees for these closely related services would also seem in order. Anecdotal evidence suggests that Medicare's CPR pricing rules for new technology, e.g., use of a flexible sigmoidoscope, are now also providing a particularly remunerative addition to medical practice.

In summary, these data suggest that further reforms should be initiated in FY 1986 for surgical fees, for specialty designation, and for high-volume increase services. The limitation of specialty designation to board-certified specialists could be enacted and scheduled at this time. A close examination and advice on fees for individual services, however, would require review of more Medicare program data than is yet available. The last section of this testimony suggests a review process, which could make use of forthcoming data and produce budget savings in FY 1986.

III. Participating Physicians and Assignment

A third area in which I believe there is a high priority for making reforms this year is in assignment policies. The need for action on such measures is particularly acute since government policy now seems to be in a period when Social Security benefits for the elderly have been (and perhaps will be) restrained.

The highest priority for assignment policy reforms should be mandatory assignment for inpatient surgical services. As discussed earlier, such fees already are inflated well beyond the hourly compensation rates for most physicians services, and surgeons, although in oversupply, still manage generous--and rapidly rising--practice incomes. As a result, there seems little social benefit to be gained from allowing even further extra-billing of the Medicare beneficiary. As well, the extra-billing for surgical services has far more troublesome economic consequences for the elderly than extra-billings for other services. In 1980, for example, the average extra-bill on surgical services was \$100 per service, compared to only \$5 for medical care.⁸ Thus, mandatory assignment for inpatient surgical services would go very far toward dealing with the extra-billing problem by non-participating physicians and would be a significant financial benefit to the elderly in a period of budgetary restraint. It would particularly benefit those elderly persons who will also already be liable for \$500 or more in out-of-pocket costs simply to pay the HI and SMI deductibles and other cost-sharing. To protect against isolated shortages, perhaps in some surgical subspecialties in some localities, the HHS Secretary could be authorized to allow extra-billing in exceptional circumstances where high quality surgical services otherwise would not be available for the Medicare program's beneficiaries.

A persuasive case, on many of the same grounds, can also be made for mandatory assignment of assistants at surgery, inpatient anesthesiology, radiology, and pathology services. In these instances, the patient has no ability to "shop around." The services are usually contracted for by the hospital, by the patient's physician or surgeon. They would thus appropriately be treated as parts of these other services and subject to the same mandatory assignment provisions which currently exist for hospital inpatient services and are suggested here for inpatient surgery.

IV. Physician Payment Assessment Commission

HCFA is making progress in developing a data base which reports what services the \$24 billion SMI program is purchasing and the fees being paid. New data files (the BMAD files), will shortly be available for 1983 expenditures, followed this fall by 1984 data. Thus, it is timely for the Congress to initiate a formal process which can serve to advise Congress, the Executive Branch, and the public about the desirability of specific payment reforms. Several of the issues discussed in this testimony could be considered in this process.

The Prospective Payment Assessment Commission (for hospital payments) provides a model for an independent, respected agency which could review Medicare payment issues and provide specific recommendations to the HHS Secretary and the Congress. A companion Physician Payment Assessment Commission could be established and requested, initially, to undertake three specific tasks. The first would be a review of which Medicare fees have become excessive because of using CPR payment methods, and specific recommendations for adjustments in such fees. The Commission's charge would include the areas discussed above: surgical fees, specialty designation, and services with high volume increases, and related policies, e.g., pricing of new technologies,

pricing differentials for similar services. As well, the statutory provisions establishing the Commission could also empower and direct the HHS Secretary, taking such recommendations into consideration, to reduce any fees paid by the Medicare program which are determined to be in excess of what needs to be paid to assure the availability of high quality, efficiently provided services for Medicare beneficiaries. The second mandate for the Commission would be to review the participating physician program and to recommend ways in which it can be expanded and the assignment rate increased by non-participating physicians. Third, the Commission should also examine whether (or in what circumstances) Medicare should pay specialty-fee differentials even for board-certified physicians.

A report of these three tasks, by April 1 of next year, would be timely when this Committee will again be considering these issues and their place in longer term reforms. If the Congress does enact further reforms next year, the Commission's mandate could be extended to conducting studies and providing recommendations on their further evolution, in a parallel fashion to the work of the Prospective Payment Assessment Commission.

Conclusion

In summary, Mr. Chairman, substantial progress in improving the Medicare SMI program could be made this year by increasing office, nursing home and home visit fees for participating physicians, reducing fees which are higher than the Medicare program needs to pay, and requiring mandatory assignment for inpatient surgery (as well as assistants at surgery, inpatient anesthesiology, radiology, and pathology). Both HHS and Congress could be assisted in these efforts by establishment of an independent Physician Payment Assessment Commission to undertake designated studies and provide recommendations.

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Mr. WAXMAN. Thank you both very much for your testimony.

You are giving us some alternatives to either extending the fee, the freeze, or lifting the fee freeze and how to be more selective in what approach we might take.

Let me just ask both of you, because you are analysts in this area, we don't know yet what is happening under the current freeze, yet we are being asked to make decisions to go along with that current freeze and extend it.

What is your best guess as to what is happening now and what would happen if it were extended?

Mr. GINSBURG. I do not have much data on what is happening now. Indeed, even if we had good information on what was happening now, it would not be that good a predictor of what would happen if we extended the freeze.

Physicians' attitudes towards a temporary freeze are likely to be very different from one that they conclude is permanent.

I have been very interested in what happened in fiscal year 1984 when SMI outlays rose at a much slower rate than they had in the previous year. I suspect that this is due to hospital prospective payment, which has reduced lengths of shorter stays imply fewer visits and fewer procedures performed.

But when I inquired, I learned that the ability to split the 1984 data into inpatient and outpatient components was not available yet. This is for 1984. So I doubt there is much information available now for 1985.

Mr. WAXMAN. Mr. Etheredge, what do you think?

Mr. ETHEREDGE. I think we have some very good evidence on changes in medical practice that are clearly within the physician's discretion and where physicians are taking actions that are saving Medicare money. They are responding to what Congress has asked them to do. Physicians are lowering the rates of admission for hospitalization, they are lowering lengths of stay and they have sharply cut back on the rate of increase in part B.

These actions which we can document in the last year are clearly actions invaluating physicians and I think they have saved \$1 to \$2 billion for the Medicare Program.

I think that needs to be recognized.

If you don't recognize it I think you will run into a problem where physicians feel unjustly treated by Medicare. And there is no doubt in my mind that if physicians want to reverse what they did last year, if they want to increase services, increase hospitalizations, and unnecessary tests, they can cost the program a great deal more money than you would possibly save in terms of a freeze.

Mr. WAXMAN. You talked about saving a great deal of money by physicians, sending patients to hospitals less or whatever, having them stay in a hospital less period of time—doesn't that have more to do with the DRG reimbursement system than it does with the freeze on physician fees?

Mr. ETHEREDGE. I think not. I think there has been so much confusion about the freeze and the DRG's this past year, that what happened is the medical care system has largely responded to the message from Washington that they should try to save money, rather than to particular economics.

For example, admission rates fell 3.3 percent last year; that is a reversal of the past 5 years. The incentives in the DRG system are to increase admissions. But in fact, admissions fell. To my mind, that is an example of the medical care system, particularly physicians, trying to save money and not simply responding to economic incentives.

Mr. WAXMAN. Do you think that is because Congress is telling them to save money or because hospital administrators are saying don't send more patients in here to take more time in the hospital beds on a basis where we will not be reimbursed the same amount?

Mr. ETHEREDGE. I think the economic incentives for the hospital administrator are to encourage physicians to increase admissions. In fact, there were decreased admissions.

Mr. WAXMAN. Do you agree with that, Mr. Ginsburg?

Mr. GINSBURG. No, I don't think we get much out of exhorting physicians to cut costs. I think the prospective payment system's economic incentives have had a large part of that. Certainly, those incentives are responsible for the decline in length of stay. The decline in admissions, of course, has been somewhat of a puzzle. I am eager to learn more though I doubt that altruism plays much of a role.

In looking at the data, one thing I noticed is that admissions for DRG 39—lens procedures—has fallen quite dramatically. It had been increasing rapidly and then from 1983 to 1984 it fell.

I suspect that this is an issue of hospitals finding they can get paid more on an outpatient basis than on an inpatient basis. That particular procedure has been one of great controversy. The hospitals say that the technology has changed between the 1981 base upon which the rates were set and 1984 and that they are underpaid under the DRG System.

Hospitals essentially moved as many cases as they could to their outpatient surgery departments in response to those incentives.

Our assumption that hospitals earn a lot of money at the margin by having an extra admission may not be correct if they can treat those same patients in their outpatient departments, get reimbursed on a cost-basis in a part of the program that never had any caps at all.

Mr. WAXMAN. It is interesting as a disagreement, whether we think physicians are acting more responsibly because we have given them the right incentives by law, or whether we think in addition to that or in place of that they are acting because of altruistic reasons.

What do you think the impact will be if we extend what the administration wants us to, the physician fee freeze? What do you think the reaction would be in the physician community to that and would we find continued success in holding down Medicare costs as a result of it?

I gather both of you agree that the administration's proposal, even the administration and Senate agreement, would anger the physician community and not produce a desired result. I don't want to put words in your mouth, but I thought that was the answer you gave earlier.

Is that a fair statement?

Mr. GINSBURG. I think it would anger the physician community. I think the most visible effect we would see would be on the participating physician concept. Fewer physicians would participate.

Overall, the assignment rate might fall because of increasing the difference between physicians' regular charges to private patients and what they can get from Medicare patients by accepting assignment.

The concerns we have about physicians billing more services, expanding brief office visits into limited ones, while it is hard to assess the degree to which that has not already been built into the system, would certainly be much greater with an extended freeze than just a temporary freeze.

Mr. WAXMAN. Do you agree with that, Mr. Etheredge?

Mr. ETHEREDGE. Yes, I do.

Mr. WAXMAN. So if we continue this freeze, it is going to be more likely doctors will be opting out of the participating physician status, is that the conclusion both of you reach?

Mr. GINSBURG. Yes.

Mr. ETHEREDGE. Yes.

Mr. WAXMAN. Second, they will not be so helpful and will look for ways, through changes in volume or mix of their services, to figure out how to earn more money when their fees are being set at 1982 levels?

Mr. GINSBURG. Yes, that is correct.

Mr. ETHEREDGE. Yes.

Mr. WAXMAN. I want to move on. You are suggesting other alternatives for us. Both of you recommend that we have selected procedures to identify and then reduce fees for.

I want to know whether you think it is really possible, and if we are concerned about the physician community reaction, what do you think the reaction would be to such an idea? And will we be able to get any consensus on what procedures should be reduced and how much?

Mr. GINSBURG. I think within the—though I may be corrected by some of your later witnesses—physician community as a whole, a focus on attaining the savings the Government needs through selected overpriced procedures might have more support than an overall freeze. I know within the physician community there is quite a bit of antagonism over this issue of very high fees for some procedures. Some groups of physicians feel that it is the half-million dollar incomes that the thoracic surgeons earn that leads to Congress imposing caps and freezes on all physicians in the Medicare Program.

So I can imagine an important segment of the physician community welcoming such a step, or at least preferring it to an extension of the freeze.

Mr. ETHEREDGE. Yes, I think it is very feasible. To my mind asking HCFA or a Commission to do this is equivalent to asking the Defense Department to see if they need to pay \$7,000 for a coffee-maker or \$400 for a screwdriver.

There are tests of reasonableness that people use on prices all the time—reimbursement per hour, the cost of the inputs involved, et cetera.

So I think it is really quite feasible to see if we can apply tests of inherent reasonableness.

Mr. WAXMAN. You suggested we try, Mr. Ginsburg, a couple of interesting demonstrations, one on physician DRG's and one on fee schedules weighted toward cognitive services.

Do we have the knowledge to do that now or do we need to wait on that?

Mr. GINSBURG. We are at the point where we don't have much knowledge in either area about the effects. But I think that a demonstration would be the fastest way to acquire the knowledge—a lot more promising than spending more time doing research.

One of the problems we have in doing research, of course, talking about relative fees, is that certain procedures that are priced very highly in one area are also priced highly in other areas. We don't have the natural variation that you need to do solid research. So I think that the most useful thing would be to go forward with a demonstration now.

Demonstrations would not be fast, of course. A well done one would take probably at least a year to plan and would need 2 or 3 years of experience and then would have to be evaluated.

So certainly the results from it would be quite far down the road.

Mr. WAXMAN. Mr. Etheredge, you suggested that the premium fee for specialists be paid only to those board certified in that specialty. How do you deal with the argument that the physician will give you that they are fully qualified, they could satisfy the Board requirements but for personal reasons they have chosen not to?

Mr. ETHEREDGE. We probably should deal with that in the same way as someone who says he is a lawyer and could pass the bar exam but he is not going to take it.

Mr. WAXMAN. Wait a second, that is licensure. Lawyers are licensed to practice law in any way whatsoever.

Doctors are not licensed to practice medicine in any way whatsoever.

Mr. ETHEREDGE. I was using an analogy—maybe a better one is the student who says he knows the course material, but he has a personal reason for not taking the exam. The point is that to pay people as a specialist or to recognize professional qualifications we have certain standards that professions agree are reasonable ones that people ought to be judged against. And I think that it is reasonable to ask someone to abide by those qualifications or those standards.

Certainly I think public policy needs some standard in this area before we start paying someone more money on the basis that in fact they really are a specialist.

I don't know what personal reasons may be a basis for objecting to board certification, but there may be some people who think that some of these standards set by specialty boards are unreasonable or are trying to restrict entry to a field. Then the approach adopted by this committee in legislation before has been to have the Secretary of HHS set up an equivalency exam. I think physical therapists, for example, have one.

So there are ways in which we can be sure the standards are fair, but I think we must insist—as in any other profession—that

clear standards must be satisfied in order to recognize higher payment.

Mr. WAXMAN. Are either of you arguing that we would have payments for certain so-called hospital-based physicians be included in the hospital DRG payment?

Mr. GINSBURG. One could include the radiologists, pathologists, and anesthesiologists in the physician DRG payments. You could include them under the hospital's prospective payment, which is subject to mandatory assignment. This is an idea you could pursue without a demonstration, since there is less uncertainty than for a broader physician DRG policy.

I agree with Mr. Etheredge's comments about those physicians that the patient never sees or never engages that our system of voluntary assignment is not appropriate. If we are going to have mandatory assignment anywhere, I think they are the prime candidates.

Mr. WAXMAN. One of the many arguments against mandatory assignment is that the access wouldn't be there; that physicians will opt out of taking medicare patients.

If you have a mandatory assignment for inpatient surgery or radiology or pathology, do you think it is a realistic concern that patients will not have access to those physicians, Mr. Etheredge?

Mr. ETHEREDGE. In general, I don't believe so, because so many of the studies in this area, such as the GMENAC study and statistics by the American Medical Association, show an oversupply of physicians, particularly surgeons. They also show surgeons now working in surgery only about 13 hours per week nationally.

There may be cases in which exceptions should be made. I think that that is something that ought to be left to an exceptions procedure run by the Secretary of HHS.

Mr. WAXMAN. Now, Mr. Ginsburg, I want to pursue some of your ideas because they are very new and different than what we are hearing.

They are offering a lot of intriguing options. We want to think them through carefully.

If you start saying that there are some fees you will reduce, as I understand your testimony, the fees that you think ought to be reduced are the ones that are overpriced. Everybody would agree with that.

The question is: Is it overpriced? You said some of these new procedures are overpriced, because when they are new they set a higher rate for them, and later, with greater experience, they can be done less costly. But we never revise the fee schedule.

You would have a panel of experts sit down and decide what procedures are overpriced; therefore, reduce the fees for them? Is that the way your idea would work?

Mr. GINSBURG. Yes, I would use an expert panel, because just using a formula would not necessarily get us the best results.

I have talked to physicians about this issue, and at least for some of the examples I mentioned there seems to be quite a consensus that these procedures are relatively overpriced. I wouldn't, in getting a consensus of experts, do a random draw of practicing physicians, but instead focus on clinical faculty in medical schools. I am not sure of the criteria, but I don't see a problem in getting a panel

of physicians together and asking them: Of the procedures done in your specialty, which ones are the ones that are relatively overpriced?

In this process I would avoid attempting to compare surgery with an office visit because then, of course, you would have a big difference of opinion among physicians. I would keep it within specialties or related specialties.

Mr. WAXMAN. It seems to me I thought you said something to the effect we ought to say to HCFA, "We want you to make selective reductions in fees," and I assume a mandatory assignment to go along with that, so it is not passed on to the patients—you figure it out, convene the experts, but be sure that the amount you are going to come up in savings will be the same as if we had a freeze across the board.

Is that a fair statement of what your testimony was?

Mr. GINSBURG. It was all fair except the mandatory assignments. I was not advocating that for these procedures. I think that it could work without mandatory assignment.

Mr. WAXMAN. Why? Wouldn't then the physician just pass on the price for what you considered an overpriced procedure to the patient where the Government is paying less?

Mr. GINSBURG. That is possible, but some of these procedures are visible enough to the patient. If the patient needs a lens procedure, this is a major undertaking. If they find there is a big difference in what it costs them between an assigned and unassigned surgeon, they would look for one that accepts assignments.

If, in fact, we found it didn't work, if the beneficiaries were paying a lot extra, then we would be able to consider mandatory assignment. I would be concerned that the mandatory assignment would be more of a political problem than lowering of the fees, and could in a sense weigh it down.

Mr. WAXMAN. Mr. Etheredge made some disparaging remarks about the idea of letting HCFA make that decision. Do you think we ought to say to them, "Go ahead and come up with a decision on that point, and save that amount of money"? Is that just passing on the buck, so to speak, to HCFA rather than the Congress making some responsible assessment and judgments of what we are going to pay less for?

Mr. GINSBURG. I wouldn't characterize it as passing it on, because I don't think Congress is in the position to actually name the procedures and the reimbursement cuts.

As far as the issue of whether to appoint a commission that reports to it, like the PROPAC, or have HCFA do it, I don't have an opinion as to which is best. I have not given it any thought.

Mr. WAXMAN. In my mind, HCFA is under tremendous pressure, as we see all the time in health policy, just to not make policy but to come up with savings in dollars. If you turn it over to HCFA, the responsibility to figure out in a selective way how to save dollars, why should I conclude that they are going to do a responsible job of doing that when they are under pressure to reduce the expenditure of dollars and may not be as sensitive in thinking through what procedures are overpriced, and where we could in fact make reductions?

Mr. GINSBURG. I can see some advantages to doing it the way Mr. Etheredge has suggested. For one thing, it would be a more visible forum to discuss these issues. Certainly HCFA has been benefitting a great deal from the deliberations of PROPAC to advise it on hospital payment. The addition of thought on hospital reimbursement issues has been substantial.

Mr. WAXMAN. Thank you very much.

Mr. Nielson.

Mr. NIELSON. Thank you, Mr. Chairman.

You both suggest the need for further reform. You both suggest that that was what was implied when the freeze was put together 15 months ago for Medicare. You both seem to feel that there is not enough information yet to go any of these routes you suggested.

The demonstration projects, Mr. Ginsburg, need to be done. Could they be done concurrently with a continued freeze? If the freeze were continued, would that preclude continued research in these areas?

Mr. GINSBURG. No. There would be no problem pursuing them at the same time.

Mr. NIELSON. I wanted to be sure. I am in favor of ending the freeze. I want to make that clear.

But we don't necessarily have to end the freeze in order to start the research?

Mr. GINSBURG. No, absolutely not.

Mr. NIELSON. Let me ask this question: Do you feel—you say the fee schedule is hard to set up an experiment for that would do much on fee schedules. You are saying DRG would be easier to handle than the fee schedule, as far as research is concerned?

Mr. GINSBURG. No. The point I was trying to make was that for the fee schedule option, I think we would learn more about it by doing a demonstration of the fee schedules with very different relative fees.

Mr. NIELSON. Who should set those fee schedules? The practicing physicians involved or the research physicians who are not performing those operations? Which would be the more objective way of determining those schedules?

Mr. GINSBURG. I misspoke when I mentioned research physicians. I don't think they would be the best people to do that. I think it would be the practicing physicians, but those who have distinguished themselves as leaders among their peers, and—

Mr. NIELSON. So you would leave it—I want to clarify that, if you would. I was unfortunately called out and couldn't hear your testimony, Mr. Etheredge. But I want to thank both of you. I had several questions, but the chairman has preempted me on most of those, so I won't ask any further questions.

But I do encourage further research in this area. It is not going to be solved today or tomorrow. We need to keep working on this. As I say, I told the HCFA people; it is a very difficult problem. We have to be fair and equitable to the medical profession and encourage people to stay in the profession and have new ones coming in.

At the same time, we have to have health care at a reasonable cost, particularly to the extent that older people depend on medicine. And I think it is important that we have a balance between the two objectives.

Thank you very much.

Mr. WAXMAN. Thank you, Mr. Nielson.

Mr. Etheredge and Mr. Ginsburg, I want to thank you as well and commend you for the work you have done and the thoughtfulness which you have given this whole question. I think we need to start looking at alternatives to just arbitrary meat-axe approaches where we say freeze everything in place and not be aware of the consequences which are obviously foreseeable and sometimes not. But, in this case, I think they are quite foreseeable in terms of the reactions to that kind of policy.

When we make decisions, there are reactions to those decisions. I think sometimes people react on altruistic motives. More often than not they react to clear signals by the Congress, and we ought to figure out what signals we are going to send rather than squeezing down and taking advantage of every opportunity we can to pay less, even if it means the doctor is treated unfairly and the Medicare patients are treated unfairly. That seems to be the least sensitive and least thoughtful way for us to make health policy questions.

I would want to talk to you again further, if not in a hearing, in another setting, so I fully understand your proposals.

Mr. GINSBURG. I would be glad to come and do that.

Mr. ETHEREDGE. Thank you.

Mr. WAXMAN. Next we have a panel of three physician groups: Dr. William Hotchkiss, vice president of the board of trustees, American Medical Association; Mr. Roehrig, president, American Society for Internal Medicine; and John Ball, associate executive vice president, Health and Public Policy, American College of Physicians.

Mr. NIELSON. While the panel is coming up, I regret that I have an appointment at Penn State College at 6 o'clock this evening and will have to leave. I am sorry I won't be able to hear your statements, but I want to make that explanation without walking out on you here. I want to explain that I have to be out of here in 10 minutes or so.

Mr. WAXMAN. We welcome you to our hearing. Your prepared statements will be in the record in full. We would like to have you summarize those statements in 5 minutes, if that is possible, so we can have full opportunity for exploring some questions and answers.

Dr. Hotchkiss.

STATEMENTS OF WILLIAM S. HOTCHKISS, M.D., VICE CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY BRUCE D. BLEHART, J.D., ASSISTANT DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION, AMA; JOHN ROBERT BALL, M.D., J.D., ASSOCIATE EXECUTIVE VICE PRESIDENT, HEALTH AND PUBLIC POLICY, AMERICAN COLLEGE OF PHYSICIANS; AND C. BURNS ROEHRIG, M.D., PRESIDENT, AMERICAN SOCIETY FOR INTERNAL MEDICINE

Dr. HOTCHKISS. Thank you, Mr. Chairman.

I am William S. Hotchkiss, and I am a physician in the practice of thoracic surgery in Chesapeake and Norfolk, VA. I am also vice

chairman of the board of trustees of the American Medical Association. Accompanying me on my left is Mr. Bruce Blehart of the AMA's Department of Federal Legislation.

The AMA is gravely concerned about the administration's fiscal year 1986 Medicare budget proposal for physician reimbursement. This proposal will erode the quality of health care, discourage physicians from accepting Medicare claims on an assigned basis and needlessly jeopardize Medicare beneficiaries' access to physicians.

In the last congressional budget cycle, the only freeze imposed was placed on physicians. Continuation of this freeze would be particularly discriminatory as only physicians would be subjected to a 2-year freeze. Moreover, because of Medicare's payment structure, reimbursement for most of 1986 will be based on 1982 charges, as you previously pointed out.

A continuation of the fee freeze and reimbursement limitations will work particularly severe hardships on physicians and their patients in situations where the physician's fees have been frozen at a relatively low charge level and where physicians did not increase their fees during the AMA's voluntary fee freeze initiated earlier.

Also, the physicians who have tried to hold the line on increasing health care costs will be the first to face the decision of having to cut back on providing care for Medicare beneficiaries. Physicians should not be penalized for their good faith efforts to hold the line on health care expenditures.

Failure to allow currently authorized increases in physician reimbursement and to terminate the fee freeze will be contrary to a commitment made by Congress. As a part of the Deficit Reduction Act, physicians—and not just participating physicians—were promised an increase in the Medicare reimbursement rate on October 1, 1985. Allowing an increase in reimbursement for only participating physicians would perpetuate and aggravate the current discrimination in the law.

The AMA supports research to examine various methodologies for physician reimbursement. While we do not think that a DRG system of payment for physician services is workable, we are actively pursuing development of a relative value study to establish resource cost-based relative values for physician services. We believe that such a reimbursement system could address inequities in payment rates for services that are predominantly cognitive in nature.

Mr. Chairman, there can be no doubt that the Medicare Program needs substantial modifications to avoid bankruptcy in the future. Congress should start addressing the long-range viability of the program. The AMA is in the process of studying proposals that would use new concepts to change funding for health care for the elderly from the current pay-as-you-go program to a self-funding program where resources would be set aside to provide real trust funds for the future. We believe that such a program could be workable, and is essential if the nation is serious about ending annual budget crises in the health care programs.

We also believe that additional sources of revenue should be used to avoid further cuts in important health care programs. Specifically, we support an increase in the cigarette tax to 32 cents per package, and we also support an increase for the tax on distilled spirits.

These additional revenues could be channeled to the Medicare trust funds and eliminate the need for a heavy cut in these important programs.

In conclusion, we support an appropriate increase for Medicare physician and hospital reimbursement, as now provided by law, unless the Congress legislates an across-the-board freeze of all domestic and defense spending as part of a broad program to reduce the Federal deficit and bring stability to the economy. Absent such an across-the-board freeze, it would be inappropriate for Medicare to continue to bear the brunt of efforts to hold the line on government spending.

Thank you for the opportunity of appearing before you. I will be pleased to respond to your questions at the appropriate time.

[The statement of Dr. Hotchkiss follows:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
United States House of Representatives

Re: Physician Reimbursement under Medicare

Presented by: William S. Hotchkiss, M.D.

April 26, 1985

Mr. Chairman, and Members of the Committee:

My name is William S. Hotchkiss, M.D. I am a physician in the practice of thoracic surgery in Chesapeake, Virginia, and I am Vice Chairman of the Board of Trustees of the American Medical Association. Accompanying me is Bruce Blehart of the AMA's Department of Federal Legislation.

The American Medical Association is pleased to have this opportunity to appear before this Committee to address physician reimbursement under the Medicare program. We are gravely concerned over the Administration's fiscal year 1986 Medicare budget proposal concerning physician reimbursement. The proposal to continue the physician reimbursement freeze and fee freeze for an additional year is highly discriminatory and unwarranted. This proposal will erode the quality of health care and jeopardize Medicare beneficiaries' access to physicians. Adoption of the proposal would mean that the Congress has reneged on its promise to

physicians that reimbursement for services would be allowed to increase on October 1, 1985, and the duration of the fee freeze would last no more than 15 months.

Mr. Chairman, let me assure you that physicians have continued to provide high quality services to Medicare beneficiaries and the rest of the population -- even in the face of the fee and reimbursement freeze and rapidly rising expenses in professional liability insurance and other practice costs. Even though the level of physician reimbursement under Medicare has not kept pace with the rest of the economy and reimbursement under other programs, the percentage of physicians treating Medicare patients has remained relatively constant, with 85% of physicians treating Medicare patients in 1984.

Physicians are committed both to holding the line on health care costs and to assuring the availability of high quality health care services. In response to an AMA call to all physicians in February 1984, physicians voluntarily agreed to freeze their charges to all patients, not just Medicare beneficiaries, for a one-year period. Approximately 80% of the nation's physicians participated in the freeze, resulting in an estimated savings of nearly \$1.5 billion dollars that otherwise would have been spent for physicians' services. The voluntary freeze was a significant factor in the recent slow-down in the rate of increase in the cost of physicians' services.

Even though the one-year voluntary fee freeze period has expired, the AMA continues to urge physicians to consider each patient's financial needs when setting charges and to accept Medicare assignment, reduce fees, or charge no fee at all in financial hardship cases.

Mr. Chairman, as noted above, we oppose continuation of the freeze on physician fees and reimbursement under Medicare. Our reasons for this opposition are:

The Fee Freeze and Reimbursement Freeze are Discriminatory

In the last Congressional budget cycle (in 1984), the only freeze imposed was placed on physicians. Continuation of the freeze would extend an unfair and extremely discriminatory practice. Other elements of the economy have not been asked to undergo similar restraints in payment from the federal government. An extension of the freeze would be particularly discriminatory as only physicians would be subjected to a two-year freeze.

Under the Deficit Reduction Act enacted last year, the increase in the Medicare prevailing rate scheduled for July 1, 1984, was eliminated, and the July 1, 1985, scheduled increase was postponed until October 1, 1985. A continuation of this policy and further postponement of increases will mean that there would be no allowed increase from July 1, 1983, through September 30, 1986 -- a 39-month freeze. Moreover, because of Medicare's payment structure, reimbursement for most of 1986 will be based on 1982 charges. Although inflation has abated since the double-digit levels of the late 1970's, a freeze for an additional year will aggravate the disparity between income and expenses for physicians and lengthen the already substantial time lag in reflecting changes in reimbursement.

Selective Increases in Reimbursement are Inappropriate

Failure to allow increases in physician reimbursement and to terminate the fee freeze, as currently provided in the law, will be contrary to a commitment made by Congress. As a part of the Deficit Reduction Act, physicians -- and not just "participating physicians" -- were promised an increase in the Medicare reimbursement rate on October 1, 1985.

Some Members of Congress have indicated that only the "participating physicians" are owed an increase in reimbursement under Medicare. This is simply not the case. Furthermore, these physicians have already been given favorable treatment under the Deficit Reduction Act as their fee profiles will be allowed to reflect increased charges made during the current fifteen month freeze. Allowing an increase in reimbursement for only "participating physicians" only would perpetuate and aggravate the current discrimination in the law.

The AMA is very concerned over the perception created by statute that there are separate classes of physicians providing care under the Medicare program. While the Medicare program now recognizes "participating" and "non-participating" physicians, in reality both groups of physicians are encouraged to provide care for Medicare beneficiaries. In some situations there is no difference between physicians in these two categories other than the label. While "participating physicians" are identified as accepting assignment on 100% of all claims, there are "non-participating physicians" who also accept Medicare claims on an assigned basis 100% of the time. Indeed, 23% of the physicians who had accepted 100% of their claims on an assigned basis prior to the participating physician program did not elect to "participate" under the new law.

When Congress promised an increase in the Medicare prevailing charge level on October 1, 1985, for all physicians, it also indicated that only "participating physicians" would be allowed to increase charges and have these increases considered in updating customary charge profiles. As payment of the customary charge level rate cannot exceed the prevailing charge level rate, a failure to grant an increase in the prevailing charge level would result in no increased Medicare reimbursement for many "participating" and "non-participating" physicians who take assignments. Congress should not break faith with physicians who acceded to inequitable reimbursement levels on the basis of their limited duration.

Continuation of the Fee Freeze and Reimbursement Limitations is Inequitable

A continuation of the fee freeze and reimbursement limitations will work particularly severe hardships on physicians and their patients in situations where the physicians' fees have been frozen at a relatively low charge level, and where physicians did not increase their fees during the AMA's voluntary fee freeze. These physicians will be penalized for their good faith effort to hold the line on health care expenditures.

Another group of physicians who will be particularly hard hit are provider-based physicians. Provider-based physicians who had been reimbursed through a combined billing process prior to October 1, 1983, did not have a customary charge profile in effect when the fee freeze was instituted. Their interim profiles pending the determination of actual customary charges were set according to "compensation-related customary charges." Because the Deficit Reduction Act prevented any redetermination of customary charge profiles, these physicians were frozen at a charge level that in many instances is dramatically below the customary and prevailing charge in the community.

Acceptance of Assignment will be Discouraged

A continuation of the Medicare reimbursement limitations and the fee freeze will discourage physicians from accepting Medicare claims on an assigned basis. This could reverse the current trend of increasing rates of assignment. The ability of physicians to accept assignment on a claim-by-claim basis is an important element of Medicare that assures beneficiaries access to virtually any physician. The history of physician acceptance of assignment bears out the fact that physicians do recognize the financial needs of their elderly patients and that they do accept assignment where warranted.

Continuing a trend started in 1976, the rate of assignment of claims has steadily increased from 51% in 1976 to 68% in February of this year.

Continuation of the Freezes will Discourage Treatment of Medicare Beneficiaries

The current fee and reimbursement freeze has already resulted in some physicians finding it difficult to continue treating Medicare beneficiaries. This has resulted in a break in physician-patient relationships as these patients have been forced to seek their care from others. A continuation of the reimbursement limitations and the fee freeze can only exacerbate these problems. For many physicians, accepting Medicare assignment and even treating Medicare beneficiaries can only be done at a loss. Those physicians who have tried to hold the line on increasing health care costs will be the first to face the decision of having to cut back on providing care for Medicare beneficiaries.

Mr. Chairman, we urge this Committee to reject the Administration's proposal to continue the physician reimbursement freeze and fee freeze under Medicare. Continuation of the freeze will fail to achieve its purpose in reduction of Medicare expenditures, and it will adversely affect the ability of the Medicare program to assure access to quality care for the nation's elderly and disabled.

The AMA also believes that additional sources of revenue should be used to avoid further cuts in important health care programs. Specifically, we support an increase in the cigarette tax to 32¢ per package. This increase would generate an additional \$6.5 billion in revenue. We

also support an increase for the tax on distilled spirits. These revenues could be channeled to the Medicare trust funds and eliminate the need for heavy cuts in these important programs. This action would both discourage abuse of alcohol and tobacco and it would help fund the care required for alcohol and tobacco related illnesses.

ALTERNATIVE PHYSICIAN PAYMENT METHODOLOGIES

The AMA supports research and demonstration projects to examine various methodologies for physician reimbursement. Such projects and studies are essential if there is to be a fair and successful modification in how physicians are paid for their services. Without adequate study, rapid modification in payment could be detrimental to the goals of health care services of high quality and continued improvement in overall health status.

Physician Payments Based on Diagnosis Related Groups (DRG)

One methodology for physician reimbursement being studied is to base payment on a fixed cost based on the patient's diagnosis. This concept is the focus of a congressionally-mandated study by the Department of Health and Human Services due by July 1985.

Just as we have continuing concerns over the hospital DRG payment program, we have strong concerns with a DRG-based physician payment plan. Even if such a plan were administratively feasible, we have grave questions over how it would affect the quality of care. A DRG system inherently gives substantial incentives to provide minimal care. The DRG methodology of payment also fails to take into account severity of illness. This is especially troublesome for those physicians who because

of specialized skill and training see patients with the most severe illnesses. Since the DRG methodology is based on "averages" and individual physicians do not ordinarily have a large enough patient population with identical diagnoses to enable costs to be spread over a larger base, a DRG system could operate as a disincentive for physicians to accept critically ill patients and could discourage necessary use of consultants.

We are also concerned about a program where all services to hospital inpatients would be based on DRGs and payment would be made through the hospital. It is evident that if both hospital and physician payments are based on a predetermined amount, all of the economic incentives will be strongly directed toward under-provision of care.

Perhaps the most serious drawback to a DRG-based payment system is that it would break down the role of the physician as the health care advocate for the patient. We never want to see the day when the "best" physician would be said to be the one who was the most "efficient" as opposed to the one who provided the best care. Because of its strong potential for adverse effects on patient care, we would object to a DRG system in the absence of proven demonstrations.

Relative Value Studies

The AMA is actively pursuing the development of a relative value study (RVS) to establish resource cost based relative values for physician services.

In January of this year the Association submitted a proposal to HCFA to develop such an RVS for all physicians' services. In late March we were informed by HCFA that relative value studies could only be developed

by universities or "think tanks" with medical organizations only participating in subcontracting roles. We currently are pursuing negotiations with a major university to submit another proposal to HCFA.

We believe that a reimbursement system based on a resource cost based relative value study could eliminate many of the uncertainties inherent in current Medicare reimbursement, and it could allow for greater competition among physicians by allowing patients a greater understanding of charges made for each service. Such a system could also address inequities in payment rates for services that are predominantly cognitive in nature.

NEED FOR LONG-RANGE ANALYSIS AND SOLUTIONS

Mr. Chairman, there can be no doubt that the Medicare program needs substantial modifications to avoid bankruptcy in the future. Even though the date of predicted insolvency for the Medicare Hospital Insurance Trust Fund has recently been set back to 1998, Congress now should start addressing the long-range viability of the program.

The American Medical Association has taken a lead role in looking for long-range solutions to today's and tomorrow's health problems. In 1982, we initiated the "Health Policy Agenda for the American People" project to develop future health policy that will assure the availability of high quality health care services for the American people. We are also looking for long-range solutions to the impending bankruptcy of the Medicare program.

The AMA has issued two major reports on the Medicare program. The first report identified a series of proposals to help assure solvency of the program for the short-term. The second report sets forth a series of

options that should be considered in any reform of the Medicare program. At this time the Association is continuing its study of proposals to change funding for health care for the elderly from the current pay-as-you-go program to a self-funding system where resources will be set aside to provide real trust funds for the future. We believe that such a program could be workable.

Congress has made a commitment that health care needs of the elderly will be met. Continued cuts in Medicare will result in a breakdown of this promise.

WAIVER OF DEDUCTIBLE AND COINSURANCE

Mr. Chairman, we are also concerned about a recent HHS action calling for sanctions against physicians in cases where physicians choose to waive collection of the deductible and coinsurance. Physicians may choose not to collect these charges when they find that such collection poses a hardship on the patient. Unfortunately, HHS sees this matter in a different light. According to a recent Program Memorandum to Medicare Carriers on this issue, HCFA is "developing a stronger range of sanctions against those who routinely waive deductible and coinsurance amounts." This Memorandum goes on to instruct carriers to "aggressively seek out instances of routine waiver and diligently enforce existing sanctions." These sanctions include heavy civil and criminal penalties.

There is a vast gulf between fraud and waiver of coinsurance for patients in need. We recognize that HHS refers to "routine" waiver, but at what point do acts of compassion and recognition of the fact that the patient simply cannot afford any copayment result in the physician facing

criminal charges? Must the physician aggressively pursue collection against the needy elderly? Because of the severe penalties involved and the uncertain area of violations, we think that the Department's action will discourage physicians from responding to the financial needs of their patients. This issue needs immediate investigation.

CONCLUSION

The American Medical Association supports an appropriate increase for Medicare physician and hospital reimbursement as provided by law, unless Congress legislates an across-the-board freeze of domestic and defense spending as part of a broad program to reduce the federal deficit and bring stability to the economy. Absent such an across-the-board freeze, it would be inappropriate for Medicare and other health programs to continue to bear the brunt of efforts to hold the line on governmental spending.

The AMA urges this Committee to reject the Administration's proposal to continue to freeze physician charges and reimbursement under the Medicare program. Medicare services are relied upon by over 30 million people, and proposals under consideration by this Committee will set program direction for years to come. Medicare beneficiaries are entitled to high quality health care services. If enacted, the budget proposals will have an adverse impact on the ability of physicians, hospitals and others to assure Medicare beneficiaries the quality of services they were promised.

Mr. WAXMAN. Thank you very much, Mr. Hotchkiss.
Dr. Ball.

STATEMENT OF JOHN ROBERT BALL, M.D., J.D.

Dr. BALL. Thank you, Mr. Chairman.

The statement of the American College of Physicians today focuses on two questions that we see as basic to discussion of physician payment policy. First: What are the issues to be addressed by any short-term modification of physician payment policy? Second: What are the principles applied to any long-term reform of the system of physician payment?

We believe that long-term reform of the reimbursement system should be an objective of health policy. That objective must be kept in mind and aided, not hindered, by short-term modifications in the present system.

Our central point is this: If our common goal for Medicare as well as for the health care enterprise generally is to do more than merely ensure the solvency of the trust fund or to save on budget costs, if our goal is, in addition, to ensure that people in need of health care have access to some societally agreed upon appropriate level of quality care, we must do more than adjust how payments are made at what level those payments may be.

First, short-term issues: One of the difficulties in focusing on the cost question of health alone, as separate from issues of quality, access and the underlying ethical base of health care, is that system changes based on economics tend to lead to responses based on economics. Unfortunately, with the exception of a portion of the PSRO Program and to some extent the prospective payment system, every legislative enactment that has addressed the Medicare Program has dealt single-mindedly with the mechanics of payment and not with the objects and goals of payment.

Present budgetary proposals for modification of physician payment center around the idea of freezing fees either in general or selectively. A general fee freeze may save on budget costs, but it does not contribute to the long-term goal of ensuring access to services by the Medicare population, nor does it enhance the appropriate use of medical services.

In addition, a general fee freeze, if applicable to all services and all physicians, breaks Government's implicit contract with participating physicians, those physicians who are making a special and honest effort to hold down their health care costs. A selective freeze on certain categories of services, certain levels of service or service price or certain services for which large variations in price exist more nearly approaches the issues of volume and service mix, but should be linked to an assessment of the medical appropriateness of the service.

There are, however, approaches other than a freeze that should be examined, and the following issues that should be addressed:

First, outmoded procedures that continue to be paid for. The Public Health Service has established a mechanism to provide Medicare with medical advice related to reimbursement, a mechanism in which the American College of Physicians participates.

However, the linkage of that advice to Medicare part B carriers claims review could be enhanced.

Second, procedures reimbursed at an artificially high level now in need of adjustment. As you have heard today, the Medicare Program has no good mechanism to readjust payment levels to account for valid changes in medical practice. Such a capability should be instituted and, indeed, enhanced.

Third, services reimbursed initially at a low level now in need of adjustment. Because of the historical charge-based nature of most third-party payment as well as statutory and contractual limitations on reimbursement agreements, valuable services such as preventive care may now be reimbursed at an artificially low level. We support a system of reimbursement based on, among other elements, the medical value of the service, and encourage the capability to adjust payment levels appropriately.

Fourth, regional variations in reimbursement levels for the same procedure. It would seem appropriate for the Health Care Financing Administration, or others, to convene advisory panels drawn from the professional medical societies to advise it on the possible explanations for regional fee variations and the degree of legitimacy of those variations.

These issues should be addressed both in the discussion of short-term modifications to physician payment and in proposals for long-term system reform. They focus attention, we believe, on what the real objective of any responsible payment system should be: to pay appropriately for appropriate services.

In addition to these short-term recommendations, our written testimony outlines a proposal we have developed in conjunction with the American College of Surgeons on long-term system reform and provides the philosophical underpinnings for that proposal. Both our short-term recommendations and our own long-term efforts are based on our primary objective in the College of Physicians; that is, to foster better clinical decisionmaking by providing the clinician with the most up-to-date information, critically reviewed, on medical technologies.

In the long run, medical practice changes for the better when the physician is able to act on valid information from a credible source.

Our long working relationship with the Blue Cross-Blue Shield Associations, to whom we provide our assessments of medical procedures, has cooperatively led to a reimbursement policy which, while still imperfect, is beginning to pay greater attention to the medical appropriateness for the service for which payment is made.

It is critical that these two tasks; that is, education on appropriate practice and economic incentives, be coupled. Neither alone is sufficient or appropriate to meet the needs we have.

Thank you for the opportunity to appear today.

[The prepared statement of Dr. Ball follows:]

STATEMENT
OF
THE AMERICAN COLLEGE OF PHYSICIANS
BEFORE THE
HOUSE ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

April 26, 1985

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

The American College of Physicians (ACP) is pleased to have this opportunity to appear before you today to outline our views on physician payment. I am John R. Ball, M.D., J.D., the College's Associate Executive Vice-President for Health and Public Policy.

The College represents over 60,000 doctors of internal medicine, subspecialists, and physicians-in-training. Our membership includes private practitioners delivering primary health care; medical specialists in such fields as gastroenterology, endocrinology, oncology, and cardiology; medical educators; and researchers. Approximately one-third of the ACP membership are Fellows of the College (FACP), a designation based upon their having met standards of scholarship and contribution to the science and practice of medicine beyond their eligibility for board certification in internal medicine.

Founded in 1915 to uphold high standards in medical education, medical practice, and medical research, the College was for many years primarily educational and honorific in nature. Increasingly, however, as payment policies have come to affect medical practice (and more recently, medical education and medical research), the College has become extensively involved, at both conceptual and practical levels, in the issues raised

by physician payment policy. Just as budget policy is linked with health policy, payment policy is linked with medical practice. And just as this Subcommittee is rightly concerned that budget policy not inappropriately affect good health policy, the College is concerned that physician payment policy not inappropriately affect good medical practice.

The College's statement today focuses on two questions we see as basic to discussions of physician payment policy:

- o What are the issues that should be addressed by any short-term modification of physician payment policy?
- o What are the principles that should be applied to any long-term reform of the system of physician payment?

We believe that long-term reform of the reimbursement system should be an objective of health policy. That objective must be kept in mind and aided, not hindered, by short-term modifications in the present system. Our central point is this: if our common goal for Medicare (as well as for the health care enterprise in general) is to do more than merely ensure the solvency of the trust fund and to save on-budget costs; if our goal is, in addition, to ensure that people in need of health care have access to some societally-agreed-upon appropriate quality of care, then we must do more than adjust how payments are made and what level those payments will be. We must, in addition, address the appropriate utilization of the tools of health care, including the knowledge base permitting, and the incentive necessary, to apply those tools. We should focus not so much on how payment is made, but, instead, on what we are all paying for.

Issues Related to Short-term Modifications

Much has been said over the past few years of the need for reform in the system of physician payment. It is quite clear, however, that no good data are yet available, nor has a true consensus emerged, to give reasonable assurance that any one system of reform is the most appropriate. We can only hope that studies now underway by the Health Care Financing Administration and by the Office of Technology Assessment will provide some information that will help in determining the direction of that long-term reform. But information alone does not constitute the only element necessary for consensus. For a true consensus to emerge, we must agree on the goals and objectives of the payment system. And we should agree on those goals and objectives, to the extent possible, prior to taking short-term steps that may hinder the achievement of our long-term goals.

One of the difficulties in focusing on the cost question alone as separate from issues of quality, access, and the underlying ethical base of health care is that system changes based on economics tend to lead to responses based on economics. This is not to say that change should not occur, that policy decisions should not be made until all possible relevant data are collected, until every potential outcome is known with certainty. It is to say that policy decisions potentially would be enhanced, if in addition to economic issues, clinical issues would also be addressed.

How can clinical issues be addressed as Congress attempts to balance the immediate needs for deficit reduction with the needs for long-term system reform? What we should all be able to agree upon is that Medicare,

to the extent societal consensus allows, should pay appropriately for those health services that are appropriate and should not pay for those services that are medically inappropriate. Instead, with the exception of a portion of the Professional Standards Review Organization (PSRO) program, and to some extent the Prospective Payment System, every legislative enactment that has addressed the Medicare program has dealt single-mindedly with the mechanics of payment and has not dealt with the objects and goals of payment. The history of Medicare indicates clearly that government did not care to become, to borrow former Social Security Commissioner Robert Ball's phrase of seven years ago, a "prudent purchaser." And in the words of a Washington Post editorial of last summer, "it's worth remembering that you don't save money on health costs merely by sending the bill to someone else."

Present budgetary proposals for modification of physician payment center around the idea of freezing fees, either in general or selectively. A general fee freeze may save on-budget costs, but it does not contribute to the long-term goal of ensuring access to services by the Medicare population, nor does it enhance the appropriate use of services. In addition, a general fee freeze, if applicable to all services and all physicians, breaks government's implicit contract with "participating physicians," those physicians who are making a special and honest effort to hold down health care costs. A selective freeze--on certain categories of services, certain levels of service or service price, or certain services for which large variations in price exist--more nearly approaches the issues of volume and service mix, but should be linked to an assessment of the medical appropriateness of the service.

There are, however, approaches other than a freeze that should be examined. The following issues, we believe, should be addressed by any short-term modification of the physician payment system, be that modification a selective freeze or any other step:

- o Outmoded procedures that continue to be paid for.

The Public Health Service, through its Office of Health Technology Assessment, has established a mechanism to provide the Medicare program with medical advice related to reimbursement, a mechanism that is likely to be enhanced by implementation of legislation passed last year. However, the linkage of that advice to Medicare Part B carriers' claims review could be enhanced as well. We are pleased with the direction of recent Health Care Financing Administration initiatives in this area, but believe more could be done. We have found, through the College's own working relationship with Blue Cross/Blue Shield's Medical Necessity Project over the past nine years, that a request to the physician to justify procedures that the best medical advice has determined is not normally useful is a sufficient disincentive for the performance of the procedure. As we have offered in the past, we would be happy to work with HCFA in developing medically appropriate screens for outmoded services.

- o Procedures reimbursed initially at an artificially high level, now in need of adjustment.

Medical services, by and large, are reimbursed on the basis of historical charges. Where those charges were originally high, presumably in order to take into account developmental costs and the extraordinary skill necessary to perform them, high reimbursement levels may no longer be justifiable because of efficiencies in utilization and advances in medical skill. In any event, the Medicare program has no good mechanism--except, in some cases, through acting on recommendations of the Prospective Payment Assessment Commission--to readjust payment levels to account for valid changes in medical practice. Such a capability should be instituted and enhanced.

- o Services reimbursed initially at a low level, now in need of adjustment.

Over time, we as a society have recognized that certain services have a greater value in relation to others. Preventive health care that supports preventive health practices is one example. A pure market economy would allow such services to be priced at a level commensurate with their perceived benefit. But because of the historical charge-based nature of most third-party payment, as well as statutory and contractual limitations of reimbursement agreements, those valuable services may now be

reimbursed at an artificially low level. We support a system of reimbursement based on, among other elements, the medical value of the service, and encourage the capability to adjust payment levels appropriately.

- o Regional variations in reimbursement levels for the same procedure.

There are thought to be wide regional variations in the reimbursement levels by Medicare for the same procedure. The extent to which this situation exists should be fully documented and the reasons for its existence fully explored. Although professional societies alone are most probably prevented by law from making judgments of the fees charged by individual practitioners, it would seem appropriate for the Health Care Financing Administration to convene advisory panels drawn from the professional medical societies to advise it on the possible explanations for regional fee variations, and the degree of legitimacy of those variations. We support the free interchange between reimbursers and the profession on what constitutes the appropriate range of medical practices. Just as the reimbursers should not make such judgments alone, neither should the profession opt out of our responsibility to identify, based upon the best information and experience, what are the reasonable parameters of practice.

These issues should be addressed both in discussions of short-term modifications to physician payment and in proposals for long-term system reform. They focus attention, we believe, on what the real objective of any responsible payment system should be: to pay appropriately for appropriate services. To be a prudent purchaser, government must move to consider what it is buying, not simply the price it is paying.

Principles Applicable to Long-term System Reform

The American College of Physicians has a long history of practical experience in enhancing the appropriate use of medical technologies. Our educational activities for physicians encompass over 100 scientific meetings per year, ranging from small postgraduate courses to an annual scientific meeting that involves 10,000 physicians in more than 400 separate sessions. Our scientific journal, the Annals of Internal Medicine, reaches over 100,000 subscribers. Most important is our technology

assessment activity, the Clinical Efficacy Assessment Project (CEAP), which over the past decade has examined in depth and made recommendations on the clinical use of more than 150 procedures in internal medicine.

Our objective is to foster better clinical decision-making by providing the clinician with the most up-to-date information, critically reviewed, on medical technologies. What we have found is that, in the long run, medical practice changes for the better when the physician is able to act on valid information from a credible source. Equally important is our working relationship with the Blue Cross and Blue Shield Associations, to whom we routinely provide our assessments, and who use those medical assessments in establishing reimbursement policy--a policy which, while imperfect, is beginning to pay greater attention to the medical appropriateness of the service for which payment is made rather than simply to how much or at what level payment is made. It is critical that these two tasks--education on appropriate practice and economic incentives--be coupled. Neither alone is sufficient or appropriate to meet the need.

Building on our experience in technology assessment, we have developed, in conjunction with the American College of Surgeons, a draft research protocol that would provide a mechanism to value medical services in a way that makes sense medically. Again with the College of Surgeons, we have participated in the development of, and endorsed, a second proposal, now submitted to the Health Care Financing Administration, that would use a consensus-based approach to value services in internal medicine and in surgery.

The College followed a set of principles in developing our approach to payment system reform, principles we believe lead practically to a clinically-effective reimbursement system:

- o First, the goal of the payment system should be to pay appropriately for effective services.
- o Second, it should not perpetuate incentives for excessive, inappropriate, or ineffective care.
- o Third, it should be based, to the extent possible, on objective, quantifiable data, rather than on historical or normative charges, "opinions," or anecdotes.
- o Fourth, it should be flexible enough to foster effective innovation and to be modified in the face of valid changes in medical practice.
- o Fifth, it should take the patient into account.

What, then, might be the outline of a clinically effective reimbursement system? A modification of the service-based reimbursement system, based on resource use; that also takes into account the effectiveness of the service and the outcome of the patient, has merit. We should ask, both clinically and economically: is this service valid for this patient?

How would such a system be designed?

- o First, the fragmented steps of a coherent service should be combined, where such fragmentation now exists.
- o Second, resource use--that is, time, intensity of effort and degree of skill, level of training, and overhead--should be calculated from a combination of measurable data and consensus opinion.
- o Third, the effectiveness of the service--defined as its ability, under usual clinical conditions, to carry out its intended function--should be calculated from data, some of which is available, much of which must be developed.
- o Fourth, the outcome for the particular patient--cure, palliation, prevention--may for certain services be factored in, giving the physician an incentive for increased involvement in the patient's care, as in providing preventive services that significantly promote health.

The merits of such a system are that it is based on service and time, two readily measurable--and monitorable--factors; that it accounts for legitimate differences in service provision (the resources actually used); that it promotes the use of effective services (by paying more for those that are highly effective, less for those that are less effective, keeping resource costs constant); and that, on appropriate occasion, it takes the individual patient, and the patient's outcome, into account.

Now, such a suggestion is necessarily incomplete--incomplete because it focuses on clinical effectiveness rather than, as other proposals, focusing on economic incentives. What it now needs, as, indeed, every such proposal needs, and should benefit from is the sort of balanced discussion among all legitimate participants at the policy table. None of us alone has the answer, or even a substantial part of it. But all of us together, from our several perspectives, have the opportunity, if we were to take it and work responsibly together, to begin to develop steps that will enable us to better the health of our population, to increase the likelihood that needed and appropriate services are received by our population and appropriately paid for. In so doing, we may or may not ensure the solvency of Medicare or solve the budget deficit problem. If we have, we will have met a more important goal along the way; if we have not, we will at least know the real costs of providing appropriate care, and will be more intelligently able to discuss the real societal tradeoffs in light of finite resources.

Thank you, Mr. Chairman, for the opportunity to appear today. I would be pleased to respond to any questions you may have.

Mr. WAXMAN. Dr. Roehrig.

STATEMENT OF C. BURNS ROEHRIG, M.D.

Dr. ROEHRIG. Thank you, Mr. Chairman. I am an internist in private practice in Boston, and am president of the American Society of Internal Medicine.

On my right accompanying me today, is Mr. Robert Doherty, director of Medical Services and Government Affairs for the Society.

Today, I would like to leave you with three important thoughts:

First, ASIM's 18,000 internist-members believe long-term reform in the physician reimbursement system is essential. At the same time, we are concerned that short-term measures may cause considerable harm to Medicare patients, and this must be avoided.

Second, if Congress believes that reducing the Federal deficit requires short-term measures to restrain part B expenditures, then ASIM strongly urges consideration of several alternative options that will result in savings in the fiscal year 1986 budget without the harmful effects of the administration's proposal for an across-the-board freeze on Medicare reimbursement.

Third, inefficient administration of the Medicare Program by HCFA's contractors, that is, the carriers, is undermining physician support for the Medicare Program in general and more specifically, is undermining support for the new Participating Physician Program created by the Deficit Reduction Act of 1984.

Unless the Health Care Financing Administration takes immediate steps to assure that the program is administered efficiently, effectively and equitably on the local level, then the trend toward increased acceptance of Medicare assignment will likely be reversed.

I will briefly explain the basis for our concerns. A written statement discussing these concerns in greater detail has been submitted for the record.

First, let me speak of the avoidance of short-term proposals that will do damage to the Medicare Program. ASIM strongly favors long-term changes such as basing approved amounts on a relative value scale that takes into account the time, complexity, overhead and other resource cost factors involved in providing each physician service which will reduce the current incentives for high-cost technological services.

ASIM strongly opposes the administration's proposed extension of the Medicare fee freeze. During the current and proposed freeze, costs incurred by physicians, as measured by the Consumer Price Index and surveys on overhead costs, have increased and are expected to continue to increase at a significant rate.

Given this reality, ASIM believes that extension of the freeze will harm Medicare patients by resulting in curtailment of services and possibly higher program costs in the long run.

Increased out-of-pocket costs will also result as nonparticipating physicians are forced to decrease the number of times they accept assignment on services in order to make up for the growing differential between Medicare's approved amounts and an amount that would represent appropriate and fair marketplace allowance for their services.

Next, let me speak of the alternative short-term proposals. If Congress determines that there is a need to enact some immediate measure to reduce outlays for physician services under Medicare, ASIM encourages and urges consideration of the following alternative options:

First, extend the freeze for all services except physicians' cognitive services, such as office visits and consultations, that currently are undervalued by the existing system.

Second, extend the freeze only for those higher-cost services with prevailing charges in each locality over a certain specified dollar level, such as \$100 or \$150.

Third, extend the freeze only for part B services rendered to hospital in-patients. The first two options would enable allowances and fees for cognitive services, those that are currently undervalued, to rise to reflect higher overhead costs. As a result, physicians would not face the same economic pressure to curtail services as would be the case under the across-the-board freeze.

Option three, the freeze on in-hospital services only, has the advantage of applying the freeze only to the setting where the highest-cost services and the majority of Medicare physician expenditures take place.

All three options also lessen the tendency of the freeze to increase patient out-of-pocket expenses by making it more likely that physicians will accept Medicare's approved amount for their cognitive services as payment in full.

Most importantly, unlike the administration's proposal, these alternatives would represent an important first step in creating appropriate incentives to reward hands-on cognitive services rather than high-cost technological medicine.

ASIM also urges Congress to enact legislation to establish allowances for new procedures on the resource costs required to provide such services, so that as the costs and risks of providing the service decrease over time, allowances will decrease accordingly.

Finally, I would like to speak a few more words about inefficient administration of the Medicare Program. ASIM has submitted for the record several letters that document the substantial administrative problems encountered by participating physicians in dealing with the Medicare Program.

Those problems include significant delays, by as much as 3 or even 4 months, in receiving payment for claims to Medicare carriers; the apparent unwillingness and inability of carriers to return telephone calls and respond to inquiries on administrative matters; miscoding of claims; incorrect denials of payment; errors in developing physicians' customary charge profiles, and failure to accurately report and follow HCFA's policies and directives; also, failure to correctly list which physicians are participating, as has been commissioned.

ASIM strongly urges Congress to use its authority to determine why these problems are occurring and to encourage HCFA to take prompt action to get these problems resolved; to investigate specifically whether or not the delays in paying claims are due to a deliberate policy decision by the inspector general of the Department of Health and Human Services to improve the Medicare Program's cash flow at the expense of reimbursing physicians and patients in

a timely manner; to appropriate, if necessary, additional funds to HCFA to assure that adequate resources are available to administer the program effectively.

I will be pleased to try to answer any questions from the committee.

[Testimony resumes on p. 717.]

[The written statement and attachments of Dr. Roehrig follow:]

WRITTEN STATEMENT
OF THE
AMERICAN SOCIETY OF INTERNAL MEDICINE

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1 BACKGROUND

2
3 The Reagan Administration has proposed a one year extension of the
4 current freeze on Medicare reimbursement for physicians' services as
5 part of its fiscal year 1986 budget proposal. This would continue the
6 existing freeze, mandated by the Deficit Reduction Act of 1984, for an
7 additional 12 months beyond the current September 30, 1985 expiration
8 date.

9
10 The Deficit Reduction Act of 1984 also established a "participating
11 physician" program that gives physicians the option of choosing to
12 become "participating physicians" in Medicare by agreeing to accept
13 assignment on all Medicare claims. (When assignment is accepted on a
14 claim, a physician agrees not to charge the beneficiary more than the
15 government's "approved charge.")

16
17 Under current law, participating physicians may increase their actual
18 charges (i.e., the physician's actual billed fee for a service) during
19 the freeze period and have those increases reflected in their customary
20 charge screens, which would be updated on October 1, 1985 to reflect
21 these charges. Non-participating physicians are prohibited by the Act
22 from increasing their actual charges to Medicare patients. Those
23 physicians, however, retain the right to decide whether or not to accept
24 assignment on an individual case-by-case basis. This program will be
25 continued in F.Y. 1986 under current law.

1 The Reagan administration's fiscal year 1986 (October 1985-September
2 1986) budget proposal, if adopted by Congress, would (1) extend the
3 freeze on Medicare's customary and prevailing charges (the basis for
4 determining Medicare reimbursement) through September 30, 1986 for both
5 participating and non-participating physicians and (2) extend the freeze
6 on actual charges of non-participating physicians for the same one year
7 period. Participating physicians would be permitted to increase their
8 actual charges, but would not receive an update of their customary
9 charge profiles to reflect those charges until October 1, 1986--12
10 months later than under current law.

11 12 OVERVIEW OF ASIM POSITION

13
14 The American Society of Internal Medicine (ASIM) is a national medical
15 society consisting of physicians who are recognized as specialists in
16 internal medicine. ASIM is strongly opposed to an extension of the
17 physician fee freeze under Medicare and urges consideration of
18 alternative means of moderating the expenditures on Medicare Part B.
19 After 20 years of experience with the Medicare program, the Society
20 strongly believes that some structural reforms are needed in the method
21 by which physicians' services are reimbursed under the program. ASIM's
22 proposals for making long term changes in the physician reimbursement
23 system are summarized later in this paper. Congress should avoid
24 measures, however, such as a one year extension of the freeze, which for
25 the reasons discussed later will result in (1) curtailment of services
26 to beneficiaries (2) increased patient out-of-pocket expenses (3)

1 increased Medicare expenditures over the long term (4) cost shifting to
2 non-Medicare patients and (5) perpetuation of the current incentives for
3 high cost technology.

4
5 ASIM opposes the extended freeze despite the fact that it was the first
6 physician organization to endorse a temporary freeze on Medicare
7 payments for physician services, taking a position in favor of a one
8 year freeze in February 1983. The Society supported proposals for
9 single year freezes in both the administration's FY 1984 and FY 1985
10 budgets, based on its belief that all sectors of the economy--including
11 physicians--must do their parts to restore economic prosperity. For the
12 same reason, ASIM has urged internists to continue to be responsive to
13 the financial circumstances of individual patients, and endorsed the
14 American Medical Association's (AMA) February 1984 call for a one year
15 voluntary freeze on all physician charges.

16
17 The profession's voluntary freeze--coupled with the existing freeze on
18 Medicare reimbursement included in the Deficit Reduction Act of 1984--
19 demonstrates that the medical profession has made a significant
20 contribution to deficit reduction and has been responsive to the
21 financial needs of their patients. It should be noted that physicians
22 were the only group to be placed under price controls in 1984.

23
24 As discussed in detail below, however, extension of the Medicare freeze
25 beyond a one year period, would have major detrimental effects on the
26 Medicare program.

EFFECTS ON MEDICARE PROGRAM

Curtailement of Services to Medicare Patients

Continuation of the freeze would result in the so called "reasonable charges" for FY 1985-86 being based on actual charges submitted during charge year 1982--an unacceptable four year gap between Medicare allowances and actual charges. This gap is even greater in those cases where Medicare's prevailing charge for a given service is controlled by the Medicare economic index, which limits annual increases in prevailing charges to the amount the federal government calculates practice costs have increased since 1971. For those services, this often results in Medicare's approved amount being much less than what physicians were actually charging in 1982.

The proposed freeze--coupled with the existing economic index limitations on prevailing charges--fails to recognize that the costs incurred by physicians in providing services to their patients have continued to increase at a steady rate. As summarized in the attached graph, from July 1982 (the midpoint of the charge year the freeze is based on) to February 1983 the Consumer Price Index-Urban (CPI-U)* increased by 8.6% (all items) and by 11.0% (all services). From 1982 to 1983 alone, physicians' average overhead costs increased by 9.6% while

* The CPI-U measures changes in prices for the 80 percent of consumers living in urban areas.

1 for internists that one year increase was 15.4%.¹ The Congressional
2 Budget Office (CBO) has projected that the CPI-U will increase by 3.9%
3 in calendar year 1985, and 4.5% in calendar year 1986, meaning that the
4 CPI will have increased at an approximate cumulative rate of 17.0% from
5 July, 1982 through December, 1986.²

6
7 As costs continue to increase for the next two years, further delays in
8 updating Medicare allowances will inevitably result in a curtailment of
9 services to beneficiaries. This will occur if physicians find in the
10 face of rising costs that they can no longer provide beneficiaries with
11 the same level of services in 1986 for the fee they charged in 1982.
12 This will be even more likely with physicians whose allowances would be
13 frozen at levels even lower than 1982 actual charges, due to the
14 Medicare Economic Index limitations.

15
16 A recent CBO report supports the conclusion that enactment of the freeze
17 could result in curtailment of services to beneficiaries. In its
18 February, 1985 report to Congress on Reducing the Deficit: Spending and
19 Revenue Options, CBO notes that:

1 Extending the freeze would mean that allowed fees under Medicare
2 will have been unchanged since July, 1983 for all physicians, even
3 those with relatively low fees. This could increase reluctance of
4 physicians to treat Medicare patients.³

6 **Increased Patient Out-of-Pocket Costs**

7
8 Extension of the freeze on Medicare allowances and actual charges of
9 "non-participating" physicians would also increase out-of-pocket costs
10 for the vast majority of beneficiaries who continue to receive care from
11 the over 70% of physicians who have not elected to become
12 "participating" physicians. This would occur if non-participating
13 physicians are forced to decrease the number of times they accept
14 assignment on services rendered to Medicare patients in order to make up
15 for the growing differential between Medicare allowances (which would be
16 based on actual charges up to four years old) and the amount that would
17 represent an appropriate and fair "marketplace" allowance for their
18 services.

19
20
21 As long as physicians' overhead costs continue to increase, but Medicare
22 allowances remain frozen at 1982 levels or less, physicians will find it
23 to be increasingly difficult--despite their commitment to remain
24 sensitive to the financial needs of their patients--to accept Medicare's
25 allowance as full payment for their services. A decrease in assignment
26 rates with a corresponding increase in the number of times beneficiaries
27 must pay their physician's full charge would occur even if the
28 prohibition against increases in the actual charges of non-participating

1 physicians is maintained. The result will be an unfortunate increase in
2 the out-of-pocket expenses of Medicare patients--a result directly
3 opposite from what Congress intended by enacting the freeze in the first
4 place--by reversing the trend to date of increasing assignment rates.

5
6 Further, Medicare is unlikely to attract many new participating
7 physicians for the coming year if the fee freeze is extended.
8 Physicians not participating currently would be unlikely to give up
9 their option to bill some beneficiaries their full charge as long as
10 reimbursement remains frozen at a rate based on their 1982 actual
11 charges.

12
13 Similarly, If the customary charge updates for physicians currently
14 participating are not provided, the fee freeze will result in a decrease
15 in the number of participating physicians. In fact, even if the
16 scheduled customary charge increases are given participating physicians,
17 in a large number of cases actual payment for their services may
18 increase only slightly, if at all. Since Medicare pays the physician an
19 amount equal to 80 percent of his or her own customary charge (based on
20 his or her actual charges), or the prevailing charges for the community,
21 whichever is lower, an increase in participating physicians' customary
22 charges will result in higher reimbursement only if the customary charge
23 is below the prevailing charge level for that service.

24
25 Therefore, participating physicians may find that an increase in their
26 customary charges will increase their Medicare payments only for a small
27 subset of services that had April 1984-March 30, 1985 actual charges

1 (the basis for the customary charge update) that are lower than the
2 allowable prevailing charge, which would continue to be frozen at 1982
3 charge levels. It is unlikely that the fees established by
4 participating physicians in 1984-85 (their new customary charges, if
5 updated on October 1, 1985) are lower than what most physicians in their
6 community charged in 1982 (the prevailing charge). The result is that
7 the promise of increased reimbursement for participating physicians will
8 prove to be illusory as long as the freeze on overall prevailing charges
9 remains in effect for an additional year, as proposed.

10
11 Further exacerbating the situation, and making it even less probable
12 that participating physicians will renew their agreements, is the manner
13 in which payments of claims to such physicians has been handled by many
14 of Medicare's contractors. Attached to this statement are several
15 letters from participating members who have received payment several
16 months after submitting a claim to Medicare. Carriers have also paid
17 the incorrect amounts for claims and in some cases failed to accurately
18 compile the list of participating physicians that are used by
19 beneficiaries in choosing a physician. Failure to return phone calls
20 and respond to inquiries, miscoding of claims, incorrect denials and
21 profiling errors are also common. These administrative problems--
22 together with the probability that participating physicians will receive
23 little or no increase in allowances, even if their customary charges
24 (only) are updated during the second year of the freeze--is likely to
25 result in a decline in the number of participating physicians next
26 year. This would have the effect of fewer claims being taken on
27 assignment and, ultimately, higher patient out-of-pocket costs. ASIM

1 urges Congress to use its authority to investigate why these
2 administrative problems are occurring; to encourage HCFA to take
3 immediate action to remedy these problems; to specifically investigate
4 whether or not the delays in processing claims are due to a policy
5 decision on the part of the Secretary of DHHS to improve Medicare's cash
6 flow at the expense of physicians and patients; and, if necessary, to
7 appropriate additional funds to HCFA to enable it to carry out its
8 administrative functions effectively.

9 10 **Increased Medicare Expenditures**

11
12 The proposed fee freeze extension, rather than saving the Medicare
13 program money, as predicted, may cost it more, if enacted. Research
14 shows that physician price controls are not effective in curbing
15 increases in program costs. A recent study of physicians in California
16 during the Economic Stabilization Program (which limited annual
17 increases in Medicare reimbursement rates) found that:

18
19 Although physician prices per unit of service were kept down,
20 overall costs rose substantially because there was a very large
21 increase in the number of services provided, and some increase (2-3%
22 per year) in the complexity of these services during the price
23 control period.

24
25 The overall effect of controls was that total physician payments
26 from Medicare increased by 10-13% during the first year of controls,
27 and by 12 to 19 percent during the second year (depending on

specialty). After controls were lifted, total annual payments to physicians rose by only 4 to 12 percent, in spite of the fact that general inflation rates in the economy were higher.⁴

Based on this analysis, the authors concluded that controls over fees are an ineffective--and potentially counterproductive--means for limiting programmatic expenditures.

Likelihood of Cost Shifting to Private Patients

Under the proposed fee freeze extension, only charges and reimbursement for services to Medicare patients would be frozen. During the first year of Medicare's freeze, many physicians refrained from raising charges to non-Medicare patients--even though they could legally do so--in order to be in compliance with the AMA's voluntary freeze. Should the freeze be extended through September 1986, with allowances continuing to be based on 1982 charges, many physicians would likely begin to compensate by increasing charges to private patients. In this way, even if the freeze extension could save the Medicare program money, it would be doing so at the cost of shifting expenses to the private sector. For this reason, the Washington Business Group on Health (WBGH)--representing a significant number of large corporations--has expressed reservations about the administration's freeze proposal, stating that

if the freeze were to be enacted, it would achieve these dubious results . . . Encourage hospitals and physicians to shift charges to

1 private sector purchasers such as WBGH members and unions . . .
2 Force Medicare recipients to buy more Medigap insurance--which is
3 really just another form of shifting costs to beneficiary--or to
4 spend down and thus burden Medicaid programs with additional
5 budgetary pressures.⁵

6 7 **Perpetuation of Incentives for High Cost Technology** 8

9 Finally the fee freeze proposal would have the unfortunate result of
10 continuing historic inequities in compensation for various types of
11 physician services. The current physician payment system for Medicare,
12 based on the "usual, customary and reasonable" (UCR) system of
13 determining allowances, has had the affect of locking in historical
14 inequities in compensation for various types of physician services--
15 inequities due at least in part to historical variations in insurance
16 coverage for different types of services.

17
18 Historically, health insurance was created to protect patients from the
19 high cost of surgical procedures and hospitalization. Expansion of
20 health insurance benefits led to increased coverage for other procedural
21 services such as laboratory tests and X-rays, but did not include
22 coverage for equally important cognitive services, such as office visits
23 and consultations. As a result, physicians began to place greater
24 emphasis on charging for procedures, so that patients could benefit from
25 their insurance. More recently, insurance plans have begun to provide
26 coverage for office visits, consultations and other cognitive services
27 that do not by themselves involve the performance of specific diagnostic

1 and surgical procedures. Unfortunately the historical bias for
2 procedures has resulted in charging patterns and reimbursement
3 allowances that continue to perpetuate the disparity in reimbursement
4 between physicians' cognitive and procedural services.

5
6 The result is the creation of powerful monetary incentives to encourage
7 the use of technology-based services. A physician who performs an
8 expensive array of technologically intensive services will be
9 compensated at high levels, while a physician who conducts a detailed
10 physical and history examination will be paid far less. This has the
11 effect of rewarding physicians for automatically performing a battery of
12 tests and procedures, while penalizing them for carefully and
13 selectively considering whether tests and procedures are needed.
14 Similarly, surgeons are penalized for their time and effort spent in
15 consultation with patients, even though careful and time consuming
16 surgical consultations can potentially yield a decision not to operate
17 on the patient and to recommend a less costly (and possibly less
18 traumatic) form of therapy.

19
20 ASIM and others strongly believe that a change needs to be made in the
21 way physicians are paid under Medicare to neutralize this present bias
22 toward technology intensive diagnosis and treatment. Extension of the
23 freeze for another year would perpetuate the current disparity between
24 physicians' cognitive and procedural services, further postponing any
25 action to remedy this flaw in the Medicare physician payment system.

ASIM'S RECOMMENDED ALTERNATIVES TO A FEE FREEZE

ASIM believes, as indicated above, that steps should be taken this year toward the long term structural changes that are needed in Medicare. Rather than simply freezing the current system, 1985 should be viewed as an opportunity to move forward in the physician payment area. ASIM supports the introduction of appropriate incentives into the physician payment system under Medicare. Since 1983, the Society's House of Delegates, representing internist-leaders throughout the country, has been on record as supporting the concept that allowances for physician services should be based on the resource costs involved in providing each service. Resource costs are those costs (such as time, complexity, investment in original training, and overhead expenses) incurred by physicians in providing a particular service. A resource cost based system of allowances would serve as a cost saving alternative to the UCR system and other charge-based reimbursement formulas.

Specifically, as a long term measure, ASIM believes Medicare allowances should be determined by a schedule of allowances, which in turn would be based on a resource cost analysis. Consistent with this approach, ASIM has urged the administration to support an American Medical Association (AMA) proposal to HCFA to develop a relative value system based on resource costs. Reimbursement for new procedures should also be based on a resource cost analysis, so that as the costs and risks of providing the service decrease over time, allowances will decrease accordingly.

1 While the above approach would be preferred by ASIM, the Society
2 recognizes that the Congress may wish to enact some measure immediately,
3 as part of a budget reconciliation bill, to reduce outlays for physician
4 services under Medicare. In such a case, ASIM believes it would be
5 advisable to fine-tune the administration's proposed freeze extension by
6 making it selective, to recognize the current imbalance in payment for
7 physicians' services in one of the following ways:

- 8
9 1) Extend the freeze for all services except those that are solely
10 cognitive in nature, such as consultations and office, nursing
11 home, and hospital visits (See List of Cognitive Services by
12 CPT Codes, attached).
- 13
14 2) Extend the freeze only for those higher cost services with
15 prevailing charges over a certain specified dollar level
16 (e.g. \$100 or \$150).
- 17
18 3) Extend the freeze only for Part B services rendered to hospital
19 inpatients.

20
21 These options would reduce several harmful effects of the
22 administration's proposed across-the-board freeze extension. Options 1
23 and 2 would enable allowances and fees for cognitive services--those
24 that are currently undervalued based on resource costs--to rise. (Most
25 of these services would be exempted from the freeze via option 2 as they
26 are overwhelmingly those with the lower prevailing charge levels). By
27 permitting allowances for those services to increase to reflect higher

1 overhead costs, physicians will not face the same economic pressure to
2 curtail services as would be the case under an across-the-board
3 freeze. Although option 3 (freeze on in-hospital services only) has the
4 disadvantage of not providing any relief for cognitive services in the
5 hospital setting, it has the advantage of applying the freeze only to
6 the setting where the highest cost services, and the majority of
7 Medicare physician expenditures, take place. Option 3 is also
8 consistent with the incentive under the Medicare prospective pricing
9 system to shift care to the out-of-hospital setting.

10
11 In addition, these options would lessen the tendency of the freeze to
12 increase patient out-of-pocket costs, with a positive effect on
13 assignment rates for non-participating physicians. A recent study
14 funded by the National Center for Health Services Research concluded:

15
16 If cuts in Medicare reimbursement expenditures result in lower
17 reimbursement rates for routine medical services such as office and
18 hospital visits, assignment rates would be expected to drop not only
19 for this service, but for ancillary services as well, irrespective
20 of what charges take place in the ancillary services
21 reimbursement. On the other hand, simply by increasing
22 reimbursement rates for medical services, Medicare assignment rates
23 for most services would rise. Consequently, to the extent that
24 these results would hold among other samples, the Medicare program
25 could be successful in increasing assignment rates without
26 increasing total physician payments. Since the findings show that
27 assignment rates are not particularly sensitive to changes in

1 reimbursement rates for surgery, laboratory, and radiology services,
2 it might be possible to lower these reimbursement rates and raise
3 the rate for medical services, without reducing--and perhaps even
4 increasing--overall assignment rates.⁶

5
6 Most importantly, those alternatives--by beginning to reduce the
7 disparity between physicians' cognitive and procedural services--would
8 be a first step toward creating appropriate incentives to reward hands-
9 on cognitive care, rather than higher cost technological medicine.

10 11 CONCLUSION

12
13 The Reagan administration's proposed extension of the physician fee
14 freeze is ill-advised and should be rejected by Congress. It will have
15 the effect of curtailing physician services to Medicare patients by
16 continuing to base allowances for services on charges established in
17 1982 or earlier. It would reduce the number of claims on which
18 assignment is accepted by causing a reduction in the number of
19 physicians who will agree to participate, as well as a reduction in the
20 percent of cases on which non-participating physicians accept
21 assignment. The overall result will be higher patient out-of-pocket
22 costs. Research evidence shows that price controls have a history of
23 failure as cost control mechanisms. The chances for this proposal
24 failing are even greater because it freezes in place historic inequities
25 between cognitive and procedural services, thus perpetuating the current

1 incentive to perform costly tests and procedures. Finally, the
2 continuation of the freeze will lead to cost shifting to private
3 patients and payors.

4
5 For all these reasons, it will be patients (both Medicare and non-
6 Medicare) who will end up paying more under an extended freeze on
7 Medicare allowances, in the form of higher out-of-pocket expenses,
8 higher premiums for private insurance, and reduced services and access
9 to care. ASIM believes that this is too high a price to ask the public
10 to pay for any immediate, short term budget savings that may result from
11 the administration's proposal.

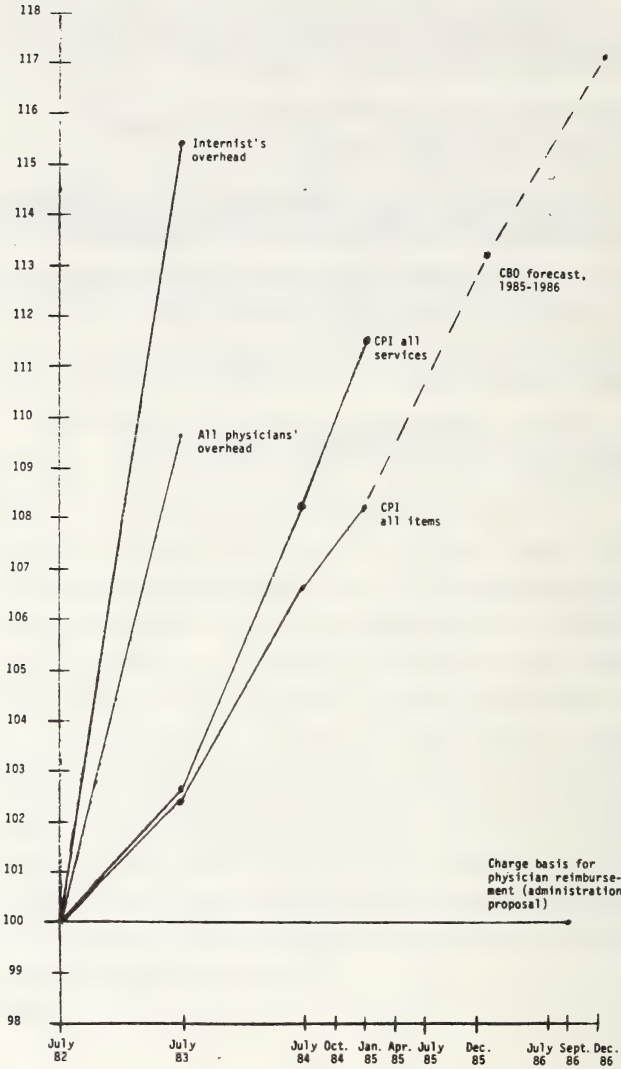
12
13 If Congress determines that some short term savings are necessary, then
14 ASIM strongly recommends that Congress consider the following
15 alternatives that would provide some relief for those cognitive services
16 that already are undervalued under the existing reimbursement system:
17 (1) extend the freeze for all services except those that are solely
18 cognitive in nature, or (2) extend the freeze only for those higher cost
19 services with prevailing charges over a certain specified dollar level
20 or (3) extend the freeze only for Part B services rendered to hospital
21 inpatients. Congress should also enact legislation to base Medicare
22 allowances for new procedures on the resource costs of providing those
23 services, so that as costs and risks decrease, allowances will decrease
24 accordingly. Unlike the administration proposals, these alternatives
25 would represent an important first step to creating proper incentives in
26 the physician reimbursement system.

T-8406

ENDNOTES

1. AMA Socioeconomic Monitoring System Core Surveys, 1981-83 in Socioeconomic Characteristics of Medical Practice, 1984, American Medical Association, Chicago, 1984.
2. Congressional Budget Office Annual Report, Part I, The Economic and Budget Outlook: Fiscal Years 1986-1990, Washington, D.C., February, 1985.
3. Congressional Budget Office, Reducing the Deficit: Spending and Revenue Options--A Report to the Senate and House Committees on the Budget, Part II, Washington, D.C., February, 1985.
4. Rice, Thomas H. and Gabel, Jon R. "Reducing Public Expenditures for Physician Services: The Price of Paying Less", in Journal of Health Politics, Policy and Law, Winter, 1985.
5. Washington Business Group on Health, Position Statement, Proposed Medicare Freeze.
6. Rice, Thomas H. "Determinants of Physician Assignment Rates by Type of Service" in Health Care Financing Review, Summer, 1984.

ATTACHMENT A



Changes in CPI, Physicians' Overhead and Charge Basis for Determining Allowances for Physician Services during Fee Freeze since July 1982 (standardized to 100 at July 1982 levels)

Note: Each increase of 1 unit over 100 represents a 1% increase over July, 1982 levels.

Table I.

ATTACHMENT B

SAMPLES OF LETTERS
FROM
PARTICIPATING PHYSICIANS
ON
PROBLEMS ENCOUNTERED WITH MEDICAR'

JAMES D. GALLANT, M.D., P.C.
Physician & Surgeon
Internal Medicine

February 27, 1985

American Society of Internal Medicine
1101 Vermont Avenue NW, Suite 500
Washington, D.C. 20005

Dear Sir or Madam:

In the recent issue of "Intercom", ASIM requested physicians to forward information on recent Medicare billing problems. In June 1984, we noticed a drastic drop in receipts despite excellent billing. A careful review of our records showed that while private insurance companies were the cause of some of our problems, the majority of our problem was due to increased delays in Medicare reimbursement. I am enclosing a copy of a letter and data that we sent to Oregon's Insurance Commissioner. We also sent this information to the Oregon Medical Association, Senator Mark Hatfield, and the Health Care Financing Administration. Although our receipts have picked up in recent weeks, our accounts receivable are still at least \$10,000 higher than they should be and our cash flow problem persists. If we can be of any further assistance to you, please feel free to contact us. Thank you.

Sincerely,


Janice A. Gallant

JAMES D. GALLANT, M.D., P.C.

Physician & Surgeon
Internal Medicine

December 24, 1984

Josephine Driscoll, Insurance Commissioner
State of Oregon, Department of Commerce
158 12th NE
Salem, Oregon 97312

Re: File #11067 HB

Dear Ms. Driscoll:

In my letter of July 18, I alleged improper delays in recent reimbursements from Medicare and other insurance companies. My allegations were based on a sharp increase in my accounts receivable last June and on my general perception of unusual delays on many accounts. My colleagues in Corvallis confirmed that they had also noted unusual delays. You replied on August 16 and requested that I provide specific examples and data. Enclosed you will find a list of 77 cases (58 Medicare, 19 other) in which reimbursement is delayed.

As I reviewed my billing records, it became clear that most of my problems have been with Medicare, though I have had some problems with other insurance providers. With several nursing home patients who I have been seeing for some time, Medicare reimbursement for nursing home visits used to take less than five weeks, and now takes eight weeks or longer (examples: James B. Carter, Eva Corrie, Irene Hofmeister). This sort of increased delay may seem minor, but when these delays are multiplied by hundreds of patients, the effects on my accounts receivable have been devastating. To give you an idea of the magnitude of the problem, I am enclosing a graph of my month-by-month billing, receipts, and accounts receivable since January 1983. You will note a sudden drop in receipts last June and a corresponding increase in accounts receivable. Receipts were good in October, but poor again in November and accounts receivable have remained unacceptably high. Since June, I have had to take out several loans simply to cover my overhead expenses.

I am convinced that most physicians have been affected by this situation. However, I feel that the effects have been more noticeable in my situation for two reasons. First, as an internist, a large percentage of my patients are Medicare recipients. Second, I have only been in practice for three years and do not have any financial cushion which would enable me to ride out these fluctuating receipts.

Page 2

It is my understanding that two states have passed laws allowing health care providers to charge interest to third party payers if reimbursement takes longer than 30 days. Such a law in Oregon would be a good way of preventing the abuses that occur under the present system. I am, after all, charged interest on the loans I take out while third party payers hold onto money that is rightfully mine. I am convinced that the behavior of third party payers in Oregon in recent months has been at the least unethical, and probably illegal. I would encourage the harshest penalties against those who are profitting at the expense of patients and health care providers.

Finally, we have noticed an increase in the frequency of Medicare and other third party payer requests for repeated claim submission (citing "technical reasons", "lost claims", etc.). We strongly suspect that these are delaying tactics used to justify unacceptable prolonged reimbursement. We have particular difficulty in collecting on deceased Medicare recipients. Medicare demands increased paperwork for deceased patients, but we feel that to a large extent, this is a smokescreen to delay payment for 6 to 8 months and longer. Because I care for many terminal patients, these policies have a substantial effect on my practice.

In this letter, I have attempted to express my frustration with the aggressive business practices of insurance companies and the bureaucratic process at Medicare. The solo practitioner is a vanishing breed; this situation is one reason why. I hope that the data and cases I have provided will help you investigate the abuses which I have alleged. I appreciate your time and attention to this matter. If I can be of any further assistance, please do not hesitate to phone or write. I am looking forward to hearing from you.

Sincerely,



James D. Gallant M.D.

cc: Jim Kroenberg, OMA
Senator Mark Hatfield

MEDICARE

<u>Patient Name</u>	<u>Date Medicare Billed</u>	<u>Date Payment Received</u>
Effie Argetsinger	6-11	8-20
Clarence Banks	6-11	none
Margaret Bedortha	6-11	9-6
Richard Bell	6-29	none
Robert Berger	3-20	none
Alice Breckenridge	6-11	none
Robert Breckenridge	9-21	none
William V. Carroll	9-21	none
James B. Carter	7-23	10-16
" "	11-19	none
Daisy Chisholm	6-11	8-20
Bennie Christensen	9-1	none
Joe Cook	5-8	8-14
Eva Corrie	11-19	none
Hannah Dale	6-11	11-8
Randall K. Dawson	4-25	none
Leota Dixon	6-11	9-4
" "	11-19	none
Louise Ede	6-11	10-12
Lyle Ellis	5-11	8-9
Lois Fields	4-12	none
Janice Forbes	11-19	none
Nellie Getzendaner	11-20	none
Margaret Graham	6-11	8-23
Elizabeth Hall	6-11	8-14
Irene Hofmeister	11-20	none
Elenora Hoke	7-23	none
Nellie Hyde	8-24	10-30
Viona Jobe	6-12	none
Eva Kitchell	6-12	8-21
Mona Kline	9-25	none
Joseph Lewis	6-29	9-18
Joseph Mehlig	5-24	8-8
Pauline Monroe	6-12	9-6
Maybell Moulton	1-6	4-3
Mary Neal	6-12	9-6
Arlene Nester	9-25	12-12
Janet Nicholaides	8-24	11-9
Mildred Pease	6-29	9-17
Ruth Pratt	7-23	10-22
Genevieve Puckett	5-24	8-4
" " "	6-12	8-28
Dorothy Pugh	5-12	7-20
" " "	8-24	10-30
Leisla Quesinberry	6-29	none
Julia Robinson	5-23	9-13
" "	9-25	12-4
" "	10-24	none

MEDICARE

<u>Patient Name</u>	<u>Date Medicare Billed</u>	<u>Date Payment Received</u>
Donald Say	6-29	12-11
Glen Simons	2-22	none
Harold Skidmore	7-23	none
Sonia Spiegel	8-24	11-8
Clara Steel	4-17	8-8
Fern Swanson	5-23	8-6
Ana Taylor	5-22	none
Letha Turner	5-26	8-9
Beulah Wenz	3-5	none
" "	10-24	none

U.S. ADMINISTRATORS (Hewlett-Packard)

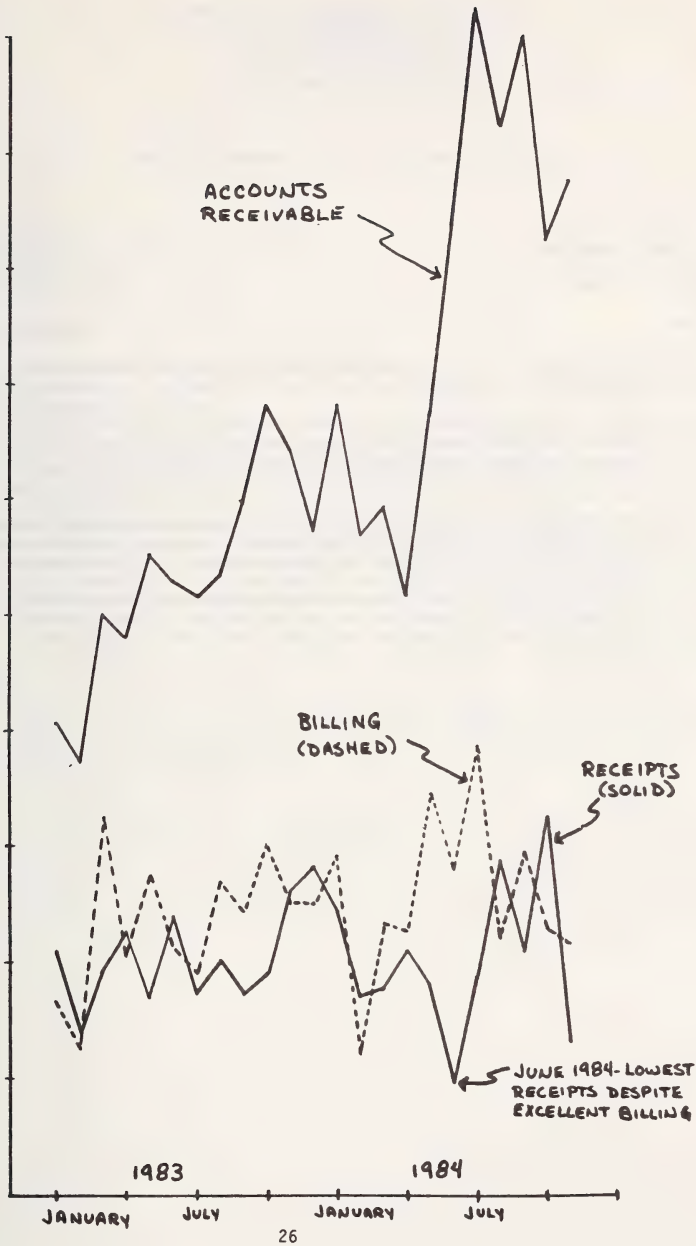
Kirsteen Hender	6-13	9-25 and 10-22
Norman Rake	5-23	none

BLUE CROSS

Elmer Fields	8-13	none
Elizabeth Hall	9-25	none
Candi Pitts	6-11	10-17

OTHER COMPANIES

Nelson Carpenter		
(Pacific NW Bell		
Plan#GA407734)	8-24	none
Freda DeCosta(NHA)	5-23	8-6
Betty Dedman		
(Travelers)	5-2	9-13
Dennis M. Dixon		
(Worker's Comp)	4-18	none
Helen Dixon		
(Great West Life		
Assurance)	8-24	none
Marvin Doleman (CNA)	4-4	none
Mary Farley(SAIF)	9-19	11-27
Annabelle Harvey(Champus)	9-18	none
Avis Karen Loeck (NHA)	5-24	8-24
Edwin Mack (OPS)	6-7	10-4
Anna Pape (NHA)	4-23	9-11
Roy C. Phillips (BC/BS		
of Phoenix, Arizona)	10-17	none
David W. Roberts (BC/BS		
of Greater New York)	9-18	none
Bruce Tompkins(Aetna)	6-25	9-6



RICHARD A. ZIEMBA, M.D. (94111)
Internal Medicine - Cardiology
 W. C. Payne Medical Arts Bldg., Suite 117
 5149 North 9th Avenue
 PENSACOLA, FLORIDA 32504
 Phone 477-8300

February 22, 1985

ASIM
 1101 Vermont Avenue NW
 Suite 500
 Washington, DC 20005

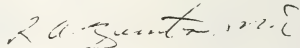
Gentlemen:

The January, 1985 Intercom newsletter discussed Medicare "participating" with some internists expressing regrets.

I can adequately vouch and document my problems and regrets in profusion. In fact, attached are copies of letters directed to the Medicare hierarchy and to the state insurance commissioner regarding these problems.

Briefly, I have always accepted assignment for hospital patients and had no difficulty with this billing. Since becoming a "participating physician" in October, 1984, and accepting assignment on office patients as well, the situation has become chaotic. Numerous letters and telephone calls to the "local" representative and also to the state office have fallen on utterly deaf ears. I have yet to receive the courtesy of a single written response to my numerous and distressing complaints. Perhaps you can use my letters to better advantage than I have by joining them with similar complaints from other unhappy and disgruntled internists.

Sincerely yours,


 R. A. Ziemba, M.D., F.A.C.P.

cp

Enclosures

RICHARD A. ZIEMBA, M.D.

Internal Medicine - Cardiology
 W. C. Payne Medical Arts Bldg., Suite 117
 5149 North 9th Avenue
 PENSACOLA, FLORIDA 32504
 Phone 477-8300

October 22, 1984

Ms. Edith Bowden
 Medicare PRR
 880 N. Reus Street
 Pensacola, FL 32501

Dear Ms. Bowden:

Since signing and mailing the "participation agreement" to Medicare, I have had the opportunity to review additional information which was not available when the agreement was signed.

Additionally, the clerical process required to file for office visits and procedures has become a time-consuming, complicated bookkeeping nightmare. Please understand the situation is frustrating and demoralizing!

Therefore, I would like to retract my agreement and become a "non-participating physician". Please permit me to return to my previous status, which was to accept assignment for all hospital patients but not for office patients.

I will appreciate your consideration of this matter and look forward to your reply.

Sincerely,

R. A. Ziemba
 R. A. Ziemba, M.D., F.A.C.P.

cp

RICHARD A. ZIEMBA, M.D.

Internal Medicine - Cardiology
 W. C. Payne Medical Arts Bldg., Suite 117
 5149 North 9th Avenue
 PENSACOLA, FLORIDA 32504
 Phone 477-8300

November 12, 1984

Medicare Part "B"
 Health Services Data
 Ms. Val Linardi
 P. O. Box 2078
 Jacksonville, FL 32231

SUBJ: EOMB error review
 R. A. Ziemba, M.D.
 Provider #17202

Dear Ms. Linardi:

For several years I have accepted assignment on all Medicare hospital patients and our claim filing and processing progressed smoothly. However, since I became a full "participating physician", the Explanation of Medicare Benefits have become error filled beyond description.

I have contacted our local professional relations representative, Mrs. Edith Bowden, who most promptly and courteously visited our office on October 23, 1984, to review our dilemma. She confirmed that my medical secretarial staff is filing claims correctly and that the error is being made at the Medicare office as a "clerical entry problem or computer problem". Mrs. Bowden states she has communicated with the state office and that the problem is being addressed. Yet, the errors are continuing and our bookkeeping problem is multiplying day by day.

May I emphasize that my two secretaries are both fully certified medical assistants whom are very competent and experienced. Both of my billing secretaries have been employed by me for 5 years and have attended numerous Medicare workshops including the one prior to the institution of "participation" on October 1st.

Thus, the bookkeeping chaos which my office is experiencing has become most discouraging and demoralizing. Each EOMB contains a few to several errors which somehow need to be adjusted and corrected. This would not be a problem if it occurred occasionally, or even once a day, but virtually every EOMB contains errors that need to be corrected. We have been dealing with office assignments for over one month now and the bookkeeping problems are becoming compounded daily. Thus, I am appealing to you to please review our situation and make the necessary corrections.

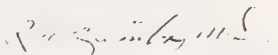
Page 2
 BOMB error review
 November 12, 1984

The following are just some of the repetitive errors occurring on the EOMBs:

1. "52 modifier" added to procedure codes.
2. "Amount billed" figure on EOMB differs from actual "amount billed" by doctor (both with and without "52 modifier").
3. For a particular procedure code the EOMB "amount billed" inconsistently varies even though our "amount billed" is constant (i.e. the difference between our reported "amount billed" and the EOMB listed "amount billed" is not a fixed amount but variable).
4. "Amount approved" varies for the same procedure code.
5. Reimbursement often sent to the beneficiary even though we list the doctor as taking assignment.

A Jacksonville office service representative recommended that we send a letter requesting an "urgent overall review" as this is needed to rectify the problem. We fervently seek, beg and implore your review of this matter because we are drowning in paperwork. Please respond rapidly to our distress call. We desperately need your HELP!

Sincerely,


 R. A. Ziembra, M.D., F.A.C.P.

cp
 Enclosures

RICHARD A. ZIEMBA, M.D.

Internal Medicine - Cardiology
 W. C. Payne Medical Arts Bldg., Suite 117
 5149 North 9th Avenue
 PENSACOLA, FLORIDA 32504
 Phone 477-8300

November 16, 1984

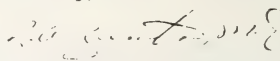
Ms. Barbara Benevento
 Director, Professional Relations
 Medicare/BCBS
 P. O. Box 1798
 Jacksonville, FL 32231-0014

Dear Ms. Benevento:

Thank you for taking time today to discuss the problems my office is having with billing for office procedures and visits. Attached is a copy of the November 12th letter sent to Ms. Linardi of the Health Services Data Department which explains the problem we have been experiencing. Samples of each of the EOMB errors are submitted as enclosures to this letter.

In accord with your telephone request, I am enclosing copies of each EOMB statement received by my office from November 14 forward highlighting the repetitive continuing errors on the statements for you. We obviously need some high-level intervention into the "system" before my bookkeeping becomes total chaos and my secretaries become berserk. We greatly appreciate your personal attention to this dilemma and will be indebted to you beyond words for its resolution.

Sincerely,


 R. A. Ziemba, M.D., F.A.C.P.

cp

Enclosures

RICHARD A. ZIEMBA, M.D.

Internal Medicine - Cardiology
 W. C. Payne Medical Arts Bldg., Suite 117
 5149 North 9th Avenue
 PENSACOLA, FLORIDA 32504
 Phone 477-8300

January 31, 1985

Mr. Bill Gunter
 Insurance Commissioner
 The Capitol
 Tallahassee, FL 32301

SUBJ: Continued Medicare Claim Errors

Dear Commissioner Gunter:

Since entering private practice in 1971, I have always accepted assignment on hospitalized patients without billing problems. However, since becoming a "participating physician" who accepts assignment on office visits as well, my office bookkeeping has multiplied beyond imagination.

The amount of bookkeeping transactions and time has sky-rocketed due to incredible and repetitive claims errors by Medicare. Numerous phone calls and letters to the Medicare representatives has established only that it is "a Medicare data entry problem" and that my office is filing properly. Yet we are over 4 months into "participating" and the errors continue. Please refer to the attached copy of my November 12, 1984 letter documenting the problems.

Considering the scope of problems and complaints the commissioner's office receives, this appeal must seem trivial to you. Nevertheless, when we have to face rectifying errors day after day, hour after hour, the problem definitely assumes magnitude to us.

Please review this ongoing insurance problem and resolve it satisfactorily. We will appreciate your efforts in our behalf.

Sincerely,


 R. A. Ziemba, M.D., F.A.C.P.

cp
 Enclosure

RICHARD A. ZIEMBA, M.D.

Internal Medicine - Cardiology
W. C. Payne Medical Arts Bldg., Suite 117
5149 North 9th Avenue
PENSACOLA, FLORIDA 32504
Phone 477-8300

January 8, 1985

Mrs. Barbara Benevento, Director
Professional Relations
Medicare
P. O. Box 1798
Jacksonville, FL 32231

Dear Mrs. Benevento:

We have received no significant corrective action from our desperate letter appeal dated November 16, 1984. There has been a minimal improvement in EOMB statement errors but these continue at a significant rate with errors being compounded. There even are errors made on our re-filed corrections necessitating a third filing of a single claim.

Another incredible ongoing error is Medicare still sending payment to the beneficiary instead of to the doctor even though we have been on 100% assignment since October 1st. As a result of the continuing errors, we are having a paperwork avalanche. This has necessitated considerable secretarial overtime to process the paperwork.

Please be assured that if the current problems are not resolved promptly, I will not renew my "physician's participation agreement" in October, 1985; also, I will report my Medicare dilemma to the State Insurance Commissioner to investigate this matter.

Sincerely yours,

R. A. Ziemba, M.D.
R. A. Ziemba, M.D., F.A.C.P.

cp

RICHARD A. ZIEMBA, M.D.

Internal Medicine - Cardiology
W. C. Payne Medical Arts Bldg., Suite 117
5149 North 9th Avenue
PENSACOLA, FLORIDA 32504
Phone 477-8300

February 6, 1985

Ms. Barbara Benevento
Director, Professional Relations
Medicare/BCBS
P. O. Box 1796
Jacksonville, FL 32231-0014

Dear Ms. Benevento:

HELP! HELP! HELP!

WHERE ARE YOU??

BOOKKEEPING SITUATION GROWING INCREASINGLY DESPERATE!

DISCOURAGED AND DEJECTED,

(Signature)
R. A. Ziemba, M.D., F.A.C.P.

cp

M.J. MANDEL & S.I. SCHNEEWEIS, M.D.S., INC.
 6801 MAYFIELD ROAD
 MAYFIELD HEIGHTS, OHIO 44124
 —
 TELEPHONE 442-8313

MORRIS J. MANDEL, M.D., Ph.D.
 STANLEY I. SCHNEEWEIS, M.D.
 LOREN S. KENDIS, M.D.

Internal Medicine
 Cardiology

March 26, 1985

Senator John Glenn
 Senate Office Bldg.
 Washington D.C. 20510

Dear Senator Glenn:

I am a specialist of internal medicine practicing in a three-physician group in the Greater Cleveland area. My associates and I elected to become participating physicians when the option was offered as part of the Deficit Reduction Act of 1984. Since only thirty percent of physicians agreed to do the same, it would be worthwhile to share our experiences and illustrate important shortcomings in the current Medicare reimbursement system. My remarks will be directed at particular problems and policies which I envision as having a negative effect on the quality of health care.

These policies do not recognize the importance of cognitive services in the overall evaluation and treatment of the patient. The current reimbursement policies discourage internists from spending additional time when it is indicated. Although the CPT coding system allows for variances in levels of care and time spent with the patient, the reimbursement is often the same regardless of the code used. In other words, I receive the same reimbursement (\$20.60) if I spend fifteen minutes or fifty minutes with an office patient. This discourages spending additional time when necessary.

We have also found that our carrier changes our codes after we submit them. The code is inevitably downgraded from one of a higher level of service to a lower level. Since our signature underlines the Medicare claim form, tampering with the codes as submitted should be illegal and carry a substantial penalty. As of this time, we have been unable to get any satisfaction from our carrier regarding this problem.

The policy of not reimbursing the physician of record for a hospital consultation is inconsistent with good medical care. A hospital consultation, even for the physician of record, at the time of

emergency or elective surgery is an important cognitive service that the internist provides for his patient and the surgeon. When that patient is acutely ill, he must be examined carefully with complete attention to the new problem as well as other chronic conditions which may also exist. There is a new set of diagnostic and management problems requiring more time and thought on the part of the consultant regardless of how long he has been the patient's physician of record. It should not be treated as a discounted service. Again, reduced reimbursement will only discourage the physician from spending the proper amount of time with the patient.

Internists are often called upon to visit a hospital patient at night between the hours of 10pm and 8am. The reimbursement for this service is \$45.60 which is \$25.00 more than a routine hospital visit. This fee discourages anyone from getting up in the middle of the night to go to the hospital and, therefore, the problem is often resolved over the telephone. This may not be in the patient's best interest.

Medicare policy currently reimburses for one comprehensive examination in the life of a patient. In an age group where most of the serious diseases occur, this is an unrealistic and ridiculous policy. We spend sixty to ninety minutes with a patient doing a comprehensive examination and, if they have had one in the past, we are reimbursed \$20.60. This again discourages spending the extra time required for a more thorough examination.

The above examples all have a negative effect on the quality of health care because the cognitive services of the internist and the value of the time spent with the patient is grossly undervalued. They also encourage an increased use of technological services as a substitute for the physician's time which in turn may actually increase the cost of medical care. In addition, these services can never take the place of a careful examination by a skillful physician. The above examples also have relevance to the DRG physician reimbursement program currently under study and how this program will also have a negative effect on patient care.

The lack of recognition of the importance of preventive care for the elderly is another area of concern in the current Medicare law. The fact that PAP smears and yearly flu immunizations are non-covered services is inconsistent with good care. Pacemaker checks for single chamber pacemakers are covered once yearly after the first year which is not in the patient's best interest. The recommendations of the Surgeon

General are quite clear regarding preventive health care for the elderly as well as the precedent set by former President Gerald Ford when he encouraged mass flu immunizations. It is paradoxical that the federally sponsored Medicare Act does not cover preventive services while official spokespersons for each administration publicly encourage them.

At a time when physician fees are frozen, and in fact decreased substantially for those participating physicians because of the reimbursement schedule, we have incurred additional overhead expenses due to the Medicare paperwork avalanche. One full-time secretary is now necessary to examine the Summary of Medicare Benefit sheets looking for reimbursement errors, code changes, inconsistencies and other mistakes by our carrier. Letters have to be written to our carrier and accounts resubmitted because of these errors. Accounts must then be altered to reflect Medicare write-offs which include odd amounts of change, making bookkeeping all the more difficult. The magnitude of the bookkeeping problem alone is enough to discourage participation in any Medicare assignment program. This, coupled with decreased reimbursement and the increased overhead makes it unlikely that we will elect to participate a second year.

If the Medicare Act exists for the benefit of its beneficiaries, it should be organized in such a way that those beneficiaries receive coverage consistent with good medical care. Since coverage for preventive services are not included, and reimbursement schedules encourage the physician to spend a minimal time with the patient, it is evident that the level of care will ultimately be compromised.

Congress has failed to inform beneficiaries of reimbursement formulas for covered service or publicized the services which are not covered. This should be done in a manner that is clearly understood by the uneducated elderly as well as the educated. If flu vaccinations are not covered, patients should know about it; if only one pacemaker check is covered in a twelve month period, the patient ought to know this and they should be told by Congress or the carrier, not by the physician alone.

Before we became participating physicians, our experience was that the patients expected more remuneration than they were entitled to and therefore became quite agitated when their expectations were not met. Since they obtained no satisfaction from contacting their carrier, they brought their anger and bitterness to the doctor's office blaming us for poor reimbursement. This only contributes to the erosion and disruption of the traditional doctor-patient

relationship.

I would like to mention one aspect of the physician fee freeze. Physicians are usually lumped together into one large group when dealt with by Congress, but certain distinctions should be made. Surgeons enjoy a much larger income than general internists, and have a low overhead since they generate most of their income operating in hospital surgical suites for which they pay nothing except the usual fee to belong to the medical staff. Internists, on the other hand, generate most of their income from their office practice, pay high rentals for adequate office space and substantial salaries for a secretarial staff and medical assistants. In addition, surgeons have always enjoyed more complete third-party reimbursement than internists. Therefore, a fee freeze will have much more of an impact on the internist.

It is difficult to manage a business which is under a fee freeze when the secretaries want raises, the suppliers charge higher prices, legal and accounting fees go up, and the rents increase. When these are added to the fee reductions of participating internists, serious financial problems can develop. If there is a physician fee freeze, all services and suppliers who deal with physicians should likewise have their fees and prices frozen in dealing with physicians. This would give the physician some protection in the marketplace.

Earlier in my letter I alluded to the DRG physician reimbursement system currently being studied by Congress. Our experiences with Medicare assignment indicate that a system such as this would have an adverse effect on the quality of care. The DRG physician reimbursement system does not allow for varied intensities of care or for subtle complications in a patient's hospital course requiring additional time spent by the physician. It almost creates economic incentives to limit care, and to provide the most basic service requiring the least effort.


A system that fails to recognize the effect of a monetary incentive for extra time spent is not likely to succeed. Physicians do not consider, before the fact, that if they spend more time they will earn more money, but after the fact, when it becomes known that they are reimbursed the same amount regardless of how much time and effort they spend, it then may become clear that extra service reaps no reward. A system such as this promotes mediocrity.

Congress cannot assume that physicians will take substantial cuts in reimbursement from Medicare assignment and DRG reimbursement systems and continue to provide the same level of care as in the past when fee for service medicine reigned. I suggest that before such a system is approved for widespread use, a careful study be done in

representative areas of the country designed to evaluate its effect on cost and quality of care.

I have outlined some serious problems which my medical group has encountered since we became participating physicians. Since I do not have the knowledge concerning budget and cost relationships, I cannot give any suggestions regarding specific areas. I do have serious concern, however, that there will be an inevitable decline in the quality of medical care if current practices continue.

Sincerely,



Stanley I. Schneeweis, M.D.
Vice Chairman, Cleveland Society
of Internal Medicine

SIS/ss

CCs: C Burns Roehrig, M.D., President ASIM
A. William Schreiner, M.D., President OSIM

WILLIAM R. ADKINS. M.D.
3702 BROADWAY
WEST PALM BEACH. FLA. 33407
PHONE 842-2560

February 25, 1985

American Society of Internal Medicine
1101 Vermont Avenue N.W. Suite 500
Washington, D.C. 20005

Gentlemen:

I was lured into the participating program last October under the cloak of greater service and efficiency for the patients. However, at this time, this has been a gross error of judgement on my part. Here in South Florida, the lapse of time between service rendered and receipt of payment has been as long as six weeks and usually is approximately one month. The low levels of reimbursement for services has certainly been a jolt to my practice and the excessive paper work has been demoralizing for the staff. I would certainly like to go on record as apposing this program and if this is what Government medicine is coming to, than I am looking forward to an early retirement.

Sincerely yours,

William R. Adkins, M.D.

William R. Adkins, M. D.

WRA/st

RIVERMONT MEDICAL CENTER

TELEPHONE 877-4556
3731 NORTH HIXSON PIKE
CHATTANOOGA, TENNESSEE 37415

February 15, 1985

RICHARD G. HOFMEISTER, M.D.
INTERNAL MEDICINE

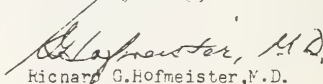
AMERICAN SOCIETY OF INTERNAL MEDICINE
1101 Vermont Avenue, N.W., Suite 500
Washington, D.C., 20005

Gentlemen:

You requested comments on being a participating medicare physician.
Here goes!

I wish I hadnot accepted! Payments are not being made direct to the physician- when Medicare was questioned about this-and I felt this was a breach of contract, my office was told several different things. One was that the charges should have been filed separately from charges where assignment was not accepted- even though the forms stated assignment applied only to unpaid balance due. Then my office was told that they had to pay the patient because the patient had already paid me more money than should have been allowed!!!! My office has maintained for many years that Medicare pays the patient back more money than the doctor. And this is proving to be true. They are not consistent with their rulings to say the least. Reprocessing of claims has been requested in order to straighten this out and they were refused. As far as collecting before Medicare makes their ruling, that is for the birds. Older people are very confused about Medicare(so are we!) and they think when you accept the assignment that is all they have to pay and will not even respond to your statements or requests for payment. This also applies to younger people who are also on Medicare for one reason or the other. In fact- they could care less! "If you don't strike the iron while it is hot, you don't get anything". Our charges are not outrageous yet they allow so little that I wonder if I'll be able to make it to September 30, 1985 when I can return to normal status! If I were a young struggling physician and had many bills to pay such as rent, mortgage payments, etc., there would be no way that I could make it. I have been in practice now for 31 years.

Yours very truly,


Richard G. Hofmeister, M.D.

635300

RGH:ehh

77 135
log

HENRY D. STORCH, M.D., F.A.C.C.

INTERNAL MEDICINE
CARDIOVASCULAR DISEASES

27 JUNE STREET
SANFORD, MAINE 04073
TELEPHONE (207) 324-6042

February 25, 1985

Dr. C. Roehrigmd, President
American Society of Internal Medicine
1101 Vermont Avenue N.W. - Suite 500
Washington, D.C. 20005-3547

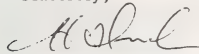
Dear Dr. Roehrigmd:

As per your request in the recent "Intercom" I would like to bring to your attention the problem which is occurring in the state of Maine.

Many physicians like myself who practice in small towns in Maine signed the Medicare participation agreement. Even if we had not signed it most of us have been in the practice of accepting Medicare assignment at least for hospitalization. Maine, on January 1st, switched over from an old coding system in which four numbers were used to the CPT-4 code system. Codes for example, that were 9027, however, are not 90270 when one switches from the old coding system to the CPT-4 code system. For some codes which the Doctor was receiving \$40 he may find that when the Medicare check arrives he is receiving only \$20. In fact this is occurring quite a bit thus creating a monumental cash flow problem for all physicians in the state of Maine and especially those who accepted assignment.

It appears to be a colossal blunder and is taxing physicians office staff and physicians pocket book quite a bit.

Sincerely,



Henry D. Storch, MD

HDS;lip

JOHN D. HELM, JR., M. D.
618 NORTH DUKE STREET
LANCASTER, PA. 17602
TELEPHONE 717 392-3596

808
MAR 11 1985
F.D.

March 8, 1985

American Society of Internal Medicine
1101 Vermont Ave., N.W.
Suite 500
Washington, D.C. 20005

Gentlemen:

You request in your Intercom a reaction to our participation in the HCFA program.

I signed the agreement to participate in this program. This was, undoubtedly, the worst economic move I have made in my career.

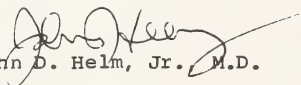
Prior to institution of this program our patients almost uniformly paid their bills. At the end of the year we submitted a medicare form and they received a check for the amount they were allowed. Everyone was reasonably happy with this arrangement. My fees have always been on the low border and now, as a participating physician, they have been reduced dramatically.

My income for January was 35% less than January, 1984.

I have no aspirations to increase my fees. I would merely appreciate the opportunity to collect my fees. Needless to say, at the end of my year's contract I will withdraw from this program promptly. In addition to reducing my income and providing a great annoyance and inconvenience to most of my patients, this has increased the volume of our office paper work by a multiple of at least six and, probably, ten.

This program is certainly not designed well. It is certainly not in the best interests of physicians. I realize this argument should not even be mentioned. I feel it is also not in the best interests of our patients.

Yours very truly,


John D. Helm, Jr. M.D.

JDH/vh

COGNITIVE SERVICES BY CPT CODES AND DESCRIPTIONS

MEDICINE

OFFICE MEDICAL SERVICES

NEW PATIENT

- 90000 Brief service
- 90010 Limited service
- 90015 Intermediate service
- * 90017 Extended service
- 90020 Comprehensive service

ESTABLISHED PATIENT

- 90030 Minimal service
- 90040 Brief service
- 90050 Limited service
- 90060 Intermediate service
- 90070 Extended service
- 90080 Comprehensive service

HOME MEDICAL SERVICES

NEW PATIENT

- 90100 Brief service
- 90110 Limited service
- 90115 Intermediate service
- 90117 Extended service

ESTABLISHED PATIENT

- 90130 Minimal service
- 90140 Brief service
- 90150 Limited service
- 90160 Intermediate service
- 90170 Extended service

HOSPITAL MEDICAL SERVICES

NEW AND ESTABLISHED PATIENT

INITIAL HOSPITAL CARE

- 90200 Brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records
- 90215 Intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records
- 90220 Comprehensive history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records

SUBSEQUENT HOSPITAL CARE

- 90240 Brief service
- 90250 Limited service
- 90260 Intermediate service
- 90270 Extended service
- 90280 Comprehensive service

HOSPITAL DISCHARGE SERVICES

(Final day of a multiple day stay)
(For a single day hospital care, use appropriate Initial Hospital Care 90200-90220)

Final Hospital Care for discharge of a patient when it includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.

- * 90292 Hospital discharge day management

SKILLED NURSING, INTERMEDIATE CARE, AND LONG-TERM CARE FACILITIES

Convalescent, rehabilitative or long-term care involves active, definitive, professional care of a patient

NEW OR ESTABLISHED PATIENT

INITIAL CARE

- 90300 Brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of hospital records
- 90315 Intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of hospital records
- 90320 Comprehensive history and physical examination, initiation of diagnostic and treatment programs, and preparation of hospital records

SUBSEQUENT CARE

- 90340 Brief service
- 90350 Limited service
- 90360 Intermediate service
- 90370 Extended service

NURSING HOME, BOARDING HOME, DOMICILIARY, OR CUSTODIAL CARE MEDICAL SERVICES

Domiciliary or custodial care involves periodic services provided to a patient who is institutionalized on a long-term basis

NEW PATIENT

- 90400 Brief service
- 90410 Limited service
- 90415 Intermediate service
- 90420 Comprehensive service

ESTABLISHED PATIENT

- 90430 Minimal service
- 90440 Brief service
- 90450 Limited service
- 90460 Intermediate service
- 90470 Extended service

EMERGENCY DEPARTMENT SERVICES

NOTES

The following listings may be used by the physician to report his services when he is assigned to the emergency department or is present in the emergency room because of other activity there, or if the physician elects to use the emergency room as a substitute for his office. (For physicians not assigned to the emergency room, see 99062-99065)

NEW PATIENT

- 90500 Minimal service

- 90505 Brief service
- 90510 Limited service
- 90515 Intermediate service
- 90517 Extended service

ESTABLISHED PATIENT

- 90530 Minimal service
- 90540 Brief service
- 90550 Limited service
- 90560 Intermediate service
- 90570 Extended service

CONSULTATIONS

For descriptions of levels of consultation, see page 5

- 90600 Limited consultation
- 90605 Intermediate consultation
- 90610 Extended consultation
- 90620 Comprehensive consultation
- 90630 Complex consultation

OTHER PROCEDURES

- 90699 Unlisted medical service, general

CRITICAL CARE

Critical care includes the care of critically ill patients in a variety of medical emergencies that requires the constant attention of the physician (cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, critically ill neonate). Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The descriptors for critical care are intended to include cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate procedure codes for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, electrical conversion of arrhythmia, etc., are excluded when this descriptor is used on a per hour basis. The physician may list his services separately if he does not wish to use this classification.

- 99160 Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each hour
 - 99162 additional 30 minutes
- 99171 Critical care, subsequent follow-up visit; brief examination, evaluation and/or treatment for same illness
- 99172 limited examination, evaluation and/or treatment, same or new illness
- 99173 intermediate examination, evaluation and/or treatment, same or new illness
- 99174 extended re-examination, re-evaluation and/or treatment, same or new illness

Mr. WAXMAN. Your comments about the administration of the program are not just for participating physicians, but for all physicians?

Dr. ROEHRIG. Yes.

Mr. WAXMAN. You are suggesting that we exempt cognitive services from a freeze extension which would reduce the incentives for high-cost technology, I presume? How would that happen?

Dr. ROEHRIG. We believe that if physicians are encouraged and have an incentive to spend time with patients, to do a thorough history and physical examination, to really sit down and find out what is wrong with the patient, using those techniques which we are quite convinced usually produce as much as 70 percent of the information needed for reaching a proper diagnosis, that the physician will find he can comfortably and safely reduce the number of laboratory tests, diagnostic studies and other procedures that involve so much money.

Mr. WAXMAN. Is it your point that cognitive services are under-reimbursed or undervalued in the amount we reimburse, and therefore, we ought to let them rise in terms of how much we pay for them, and the others are overpriced and therefore, we ought to keep a freeze on them?

Or are you saying that these services are just more valuable and can reduce the costs of medical care overall, because they can avoid the use of some of the other medical services and technology?

Dr. ROEHRIG. Both! I believe cognitive services are substantially undervalued. I think there is research that demonstrates this. Certainly the Hsiao-Stason study is one of the papers that demonstrates this, and has been referred to earlier today.

We do feel that these services are undervalued and underpriced.

Mr. WAXMAN. Your complaints about the administration's proposal would not be satisfied, however, with just an exemption for cognitive services, I assume? I assume your objections are more than just the undervaluation of this particular part of the practice of medicine?

Dr. ROEHRIG. We believe by doing this, by exempting cognitive services from the freeze, at least the first step is taken. An across-the-board freeze accomplishes nothing as far as policy is concerned. We believe that by lifting the freeze from cognitive services that at least you are beginning the step toward recognizing the undervaluation of them, and toward improving the nature of medical care.

One of the most common complaints that I hear from patients who have seen other physicians is that the doctor doesn't spend enough time with them, that they don't answer questions. There is no incentive in the system for doctors to spend time with patients as cognitive services are currently reimbursed.

Mr. WAXMAN. Dr. Ball, what is your reaction to the suggestions from our earlier panel, and maybe Dr. Roehrig's statements as well, the fees for some procedures could be reduced or some procedures could well be held in place in terms of the amount of the fee?

How would the physician community respond if we try to come up with some proposal like that?

Dr. BALL. Our proposal has suggests a reevaluation of the whole range of procedures. That is, we believe that some procedures are overreimbursed, not so much because of overvaluation, but because

of the historical nature of the ways in which they were priced; and some procedures are undervalued, and because of the reimbursement system, are underreimbursed. We would like HCFA to have a mechanism where they could readjust that reimbursement based on medical value.

With regard to how the physician community will respond, you have even heard today the physician community is not a monolith.

Physicians in various specialties may make on the average an hourly income of two to three times what physicians in other specialties make. Certainly those at the upper end of the scale might be disappointed by a freeze that is selective, while those at the lower end of the scale might be happy with that.

What all physician groups would like to see is a more rational approach in general, and the more a short-term approach leads us to a more rational approach in the long term, then the physician community would be happy with that approach.

Mr. WAXMAN. Do you think if we either put a freeze on some fees or reduced others, that we ought to couple it with mandatory assignment in order to protect the beneficiaries from simply having the fees passed on to them?

Dr. BALL. Probably not, and for a couple of both philosophical and practical reasons. First of all, mandatory assignment is seen at least as a way in which the beneficiary could be protected. What we don't know, in fact, is if mandatory assignment were required, whether the beneficiary would be adversely or positively affected. That is not an idle threat; it simply is to say that the economics of the rapidly-changing health care system are such that we don't know what physicians will do.

We do know, at least from 1983 data, that 20 percent of physicians always accept assignment, 30 percent never accept it, and 50 percent accept it sometimes. With such a large gray zone, it is impossible to predict access.

Second, there is a more practical change that might occur—that the procedures which might be assumed to decrease under mandatory assignment are those procedures for which a higher percentage of physicians accept assignment.

That is, the higher-paid specialties and the higher-priced procedures have a higher rate of assignment, so that one could expect that if you lowered reimbursement for those procedures there might not be a decrease in the rate of assignment accepted.

Mr. WAXMAN. What do you think about the idea of saying we would have a physician choose between taking assignment under all cases or none, or those areas where particularly we are going to have some kind of reduction in the fees?

Dr. BALL. We think that before you do that, you should look at the long-term implications for both access and quality, and we would still hold that we simply don't know enough to be able to make that kind of decision.

Mr. WAXMAN. If what Medicare pays is substantially less than what the physician thinks the fee ought to be, is the physician more likely to ask the patient to come up with more of the money?

Dr. BALL. If the fee is high in relation to what other physicians get or high in relation to what other subspecialties get for their kinds of procedures, it is still more likely that the physician would

accept assignment for that, because of the greater likelihood of getting payment from Medicare and the less likelihood of getting it from the patient.

Mr. WAXMAN. Dr. Hotchkiss, in your testimony, you stated that 23 percent of the physicians who had previously accepted assignment 100 percent of the time did not sign up to be participating physicians. Do you know why this happened?

Dr. HOTCHKISS. It is difficult to say why that happened. However, we do know of instances where doctors accepted assignment 100 percent of the time. They just were not willing to be locked-in to that process, if they had patients who could pay the full fee or they wanted to retain the right to bill any patients their regular fee.

Mr. WAXMAN. Dr. Davis from HCFA told us she didn't think the assignment rate would be affected by an extension of the freeze. You indicated you thought it would go down.

Can you explain why it would go down under an extension of the freeze?

Dr. HOTCHKISS. If there is an extension of the freeze, it will show a loss of the commitment of the Congress to carry out its promise. I think that the physicians will be discouraged, and they will feel it is not worth their while to continue to participate. I think that physicians will feel Congress has not kept the faith with them, and they will then decide that they will become nonparticipants.

Mr. WAXMAN. Even if they have an economic incentive because, at least under the Senate-White House proposal, would give those who do choose, who continue to be participating physicians, an actual increase in what Medicare will pay, and a potential for further increases after 12 months?

Dr. HOTCHKISS. I carefully followed your questions to the first panel on what the compromise is, and I have the same difficulty as you in getting a handle on it. As you so well stated earlier, the vast majority of physician payments under Medicare are controlled by the ceiling imposed by the prevailing charge level and not by the physician's profile. Also payments are made based on charges from several years back, 1982 and will continue to do so if the freeze is held in place. I think that continuing the freeze would have that effect.

Mr. WAXMAN. What do you think will happen if the freeze simply lapses, should we be concerned about beneficiaries being subject to large increases in charges for unassigned claims?

Dr. HOTCHKISS. I doubt that very much, Mr. Chairman. The physicians of America have demonstrated their willingness to act voluntarily to help control the cost of care. In 1984, when we asked physicians to voluntarily freeze their fees they did indeed respond. According to the studies that we made 80 percent of the physicians voluntarily froze all of their fees. In so doing, they saved the consumer \$1.5 billion in payments.

Mr. WAXMAN. Suddenly, the ceiling is lifted and there is no freeze on them from either the Government or for what they can charge their patients, since 1982 fees, if they don't take assignment, don't you expect they will raise their fees much higher and pass it on?

Dr. HOTCHKISS. I think physicians will have to raise their fees to some extent sooner or later. You have to recognize that when a

physician does not raise his or her fees, that he or she is actually taking an income cut, because the expenses of running the office and paying malpractice insurance continue to rise, as all other expenses do.

And so, when you freeze your fees and your expenses go up, your income goes down, and yet, 80 percent of the physicians of America are willing to do that. This demonstrates their commitment to trying to hold down the cost of care.

Also, we have other factors in operation at this time. We are developing an increasingly competitive environment in medicine. We have HMO's, and PPO's, and increasing numbers of doctors, so that physicians are going to the smaller communities where there previously were no physicians.

And there are many things that will act to hold the increase to a reasonable level; but, doctors cannot freeze their fees forever. I think many physicians would believe that this is what they were being asked to do, if the commitment of the Congress to loosen the freeze on October 1 were abandoned.

Mr. WAXMAN. Last time we had a voluntary effort to hold down costs, it was in the hospital area, increases in hospital rates. The hospital industry said, "We will do a voluntary program of holding it down," and they did a pretty good job.

As soon as the legislation died and their voluntary period ended, the rates went sky high. Why wouldn't we have a reasonable expectation that the same thing would happen with physicians who have been holding down their fees while their costs have gone up?

Dr. HOTCHKISS. The voluntary effort was indeed successful for 2 or 3 years. Then I think they had removed much of the inefficiency that was in the system, and it wasn't easy to effect additional savings.

I think that there are inexorable pressures on hospital costs that do push them up. It is a very high labor-intensive industry, hospitals, and I don't think the two situations are compatible.

Mr. BLEHART. Physicians have done a very good job of keeping in mind the financial situations of their individual patients. Even prior to the participating program going into effect, the assignment rate for all claims has continued to go up, and that while it was at a 53.9-percent rate for all of 1983, by September of last year, it was at a rate of virtually 60 percent. Physicians are certainly cognizant of the financial situations of their patients, and an elimination of the existing fee limits and the freeze is not going to stop that.

Mr. WAXMAN. Don't you think hospitals were cognizant of the impact to society of their increasing hospital rates and the impact on the whole health care system and the insurance payors? Didn't they want to do the best they could, as good citizens, not to have their increases go up so much. But, once their voluntary effort ended, they acted as if they were released, and the lid on the pressure cooker was removed.

It was a dramatic increase, not just a little increase. I am challenging these ideas in your response.

Mr. BLEHART. There is a differentiation.

Mr. WAXMAN. You think it is different?

Mr. BLEHART. Very much so.

Dr. HOTCHKISS. I think it is unreasonable to paint the physicians of America with the same brush that you paint the hospitals.

Mr. WAXMAN. Why?

Dr. HOTCHKISS. Why?

Mr. WAXMAN. It's just human nature that if you have price controls over time, and they are lifted, there will be a dramatic increase. It didn't mean that they were not nice guys.

Dr. HOTCHKISS. Well, they have to pick up some of the losses. Physicians have actually taken losses.

Mr. WAXMAN. It happens, and to say it won't happen because doctors are sensitive individuals, is not very convincing. They still have to pay all those extra charges that are coming, that they have so far been absorbing.

Dr. HOTCHKISS. The hospitals are becoming a more competitive industry, certainly with the for-profit hospitals coming into place so much. About 10 percent of the hospitals in the United States are for profit. We have a hospital in our city which advertises in the newspaper that they will waive the \$400 downpayment. It is more competitive.

Mr. WAXMAN. One of the ideas we are getting from a number of witnesses is that some areas of medical practice, some procedures are overpriced, and could be reduced, and I would like to know what your reaction is to this idea of reducing some fees or selectively freezing certain types of procedures.

Dr. HOTCHKISS. Mr. Chairman, to start with, I am a surgeon. I am a thoracic surgeon, not one of those \$500,000 thoracic surgeons as one of the members of the previous panel mentioned.

The AMA recognizes that cognitive services are not paid for, reimbursed as well as procedural or surgical, technical services. We have supported a position that that should be addressed.

We can't go along with the recommendations of our colleagues over here from the American Society of Internal Medicine. We think that the three examples that they want to release from the freeze are not necessarily underpaid. Just because a patient is in the hospital does not mean that the doctor is being overpaid or just because the service costs over \$100 or \$150 doesn't mean it is too high. As far as cognitive services are concerned, they are performed by surgeons, too. When I have a patient with a lung cancer and have his chest opened, and have to decide whether to take that cancer out, that lung out, and make up my mind whether I think he can survive that procedure, I have to cognate at a considerable rate. I can assure you, and I came by these gray hairs honestly, you can't readily differentiate.

We think the problems should not be addressed in a superficial manner, and we don't think the HCFA is the right organization to try to decide this. We think the relative value study would be the best way to address this problem, and it ought to be a different type of relative value scale from the ones previously used. The best known one is the one from California, which was worked out by finding how much doctors charge for each service and taking the averages to set the scale. That perpetuated inequities that already existed.

RV's ought to be a resource, cost-based relative value scale. The fees that are generally arrived at should be governed or arrived at

by looking at how much experience, training, time, and commitment of the physician is required to render the service. We think it would be more appropriate if this were done not by individually selected practicing physicians, but by a large organization that represents the physicians, and the large specialty societies. The AMA represents the practicing physicians of America and these specialty groups.

Mr. WAXMAN. Well, we have some organizations here representing practicing physicians of America who take a different point of view. Should we say you should all get together, if you can, fine, if you can't, we will just continue paying the same fees, even though there may be a disparity in a way that defies rationality.

Dr. HOTCHKISS. We think this is something that can be done, must be done, and the AMA applied to HCFA for a contract to devise a relative value study. There are 63 medical specialty societies, national specialty societies, represented in our house of delegates.

We expect to draw on their expertise and have been in contact with them. We think this would be the way to go.

But HCFA says no—it has to go to a university or to a think tank. We are currently negotiating with one of the large universities to participate with them in this effort.

Mr. WAXMAN. What do you think of the idea of having the AMA, which represents such a broad spectrum of physicians in various specialties, have a contract to decide to bring more rationality to the fee schedules?

Dr. ROEHRIG. We would support this, speaking for ASIM, and would work with the AMA in doing it.

Mr. WAXMAN. Dr. Ball.

Dr. BALL. We and the American College of Surgeons have participated in the development of a proposal from one of the large universities that has been submitted to HCFA for funding. If that proposal gets funded, we wish to go along with that project.

If the AMA proposal gets funded, we are in the AMA house of delegates as well, and would be willing to work with that project.

Mr. WAXMAN. Thank you for your participation in this hearing. You have given us some real insights into the problem we have, and the complexity of the problems we are facing, and the simplicity and thoughtlessness of the solutions that are being offered to this problem.

Dr. HOTCHKISS. Mr. Chairman, in closing, that I, for one, am impressed and appreciative of the sophistication of your subcommittee on these complicated matters.

Mr. WAXMAN. Our last panel, Dr. Monroe T. Gilmour, M.D., Boardmember, American Association of Retired Persons, Charlotte, NC; and Mr. William Hutton, executive director of the National Council of Senior Citizens.

We are delighted to welcome you. The Medicare Program was set up as a promise to the elderly in America that we are going to take care of their health care needs, and that has to be very much the primary thought on our minds as we look at these various proposals.

So I am interested in what the two of you have to say, as to how these various ideas might well affect the beneficiaries, the people

for whom we set up this program, the elderly, not the doctors, not the hospitals, not the providers, and not the Government bureaucracy, or not the Office of Management and Budget.

So we are delighted to hear from you. Dr. Gilmour.

STATEMENTS OF MONROE T. GILMOUR, M.D., BOARDMEMBER, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY CHRIS MCENTEE, LEGISLATIVE REPRESENTATIVE; AND WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Dr. GILMOUR. Mr. Chairman, I appreciate the opportunity to appear before you on behalf of the AARP to talk about what we think about the beneficiaries' rights, and also doctors' payment under medicare.

I, myself, am Monroe T. Gilmour, a physician retired after 40 years of practice, now on the board of the American Association of Retired Persons, the national board.

AARP believes that Congress should act now to bring about change in Medicare's current methods of paying physicians for the following reasons:

One, the shift to outpatient care under the DRG system will exacerbate part B spending problems and cause higher out-of-pocket costs for beneficiaries.

Two, changes in part B for budgetary savings alone will not create efficiencies which would benefit both physicians and beneficiaries.

Three, the current fee freeze elapses this October.

Medicare's current physician reimbursement system has caused overinflation in physician expenditures by encouraging rapid fee escalation and large increases in the volume of services delivered, which cannot be explained by beneficiary overuse of physician services.

In addition, the payment system has created numerous discrepancies and anomalies in physician payment such as the gap in compensation for the use of technology and procedures over cognitive services.

Medicare's coverage for physician services is less than adequate. Beneficiaries are now responsible for over 60 percent of total physician charges due under part B.

AARP is pleased to note the increasing assignment rate over the past several years. However, beneficiaries' liability for unassigned claims has increased by more than 200 percent over the same period, further eroding insurance protection against the rising cost of physician care.

Although in the absence of comprehensive reform of physician payment, AARP approaches the issue of mandatory assignment with caution, AARP does support even greater financial and administrative incentives to increase the assignment rate.

AARP believes that no payment methodology—DRG's, fee schedules, capitation, et cetera—will be appropriate for all types of physician services. While AARP does not endorse at this time a particular mix of payment mechanisms, AARP recommends that Congress enact a legislative package similar to the package which led

to reform of Medicare hospital payment which would serve as the basis for long-term physician payment reform, beginning in 1987.

AARP believes that program savings alone cannot be the sole criterion for changes in Medicare part B. If Congress finds it necessary to implement part B budgetary savings in fiscal year 1986, AARP recommends the following alternatives, which not only produce savings, but also begin to redress current payment discrepancies:

One, a freeze only on part B services rendered to hospital inpatients which would reduce the financial incentive to select expensive inpatient care.

Two, a freeze only on higher cost services or a freeze on all services except those, primarily cognitive or primary care in nature, that are currently undervalued which would allow reimbursement for those services currently undervalued to rise.

Three, a limit on high fees within each service code which would reduce geographic variations in payment which defy reasonable variations in the cost of living.

A simple extension of the current freeze on MDPHY payments would cause significant problems for both beneficiaries and physicians including a drop in the assignment rate, higher costs to beneficiaries, higher part B expenditures due to increased volume of services, and the development of a two-tier system of care.

[Testimony resumes on p. 737.]

[The prepared statement of Dr. Gilmour follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

Thank you, Mr. Chairman, for this opportunity to present the views of the American Association of Retired Persons (AARP) on Medicare physician payment. My name is Monroe Gilmour and I am a member of the Association's Board of Directors. AARP is the nation's largest membership organization of older citizens, representing over 18.3 million older Americans.

AARP commends you and your committee for your leadership on the complex issue of Medicare physician payment. We agree with you, Mr. Chairman, that Congress should begin now to bring about change in Medicare's current methods of paying physicians for the following reasons:

1. The establishment of the DRG system for Medicare hospital payment will continue to shift care provision from the inpatient to outpatient setting. If nothing is done to reform Part B, the move towards outpatient care will exacerbate Part B's current spending problems. In addition, beneficiaries' out-of-pocket costs will significantly increase since coverage under Part B is less comprehensive than coverage under Part A.
2. Even with the enactment of last year's freeze on Medicare payments to physicians, Medicare Part B

expenditures will continue to rise at an annual rate of increase of 16 percent. This rapid rate of increases places pressure on the federal budget, leading policymakers to look for program cuts based upon program savings alone rather than ways to create efficiencies in Part B which would benefit both physicians and beneficiaries;

3. The current Medicare physician fee freeze expires this October. It is timely to consider what steps can be taken when the freeze expires to rectify well-documented problems and discrepancies in Medicare's current physician payment methods.

AARP believes that Congress should begin now to implement long-term reform in Medicare physician payment and redress current payment discrepancies. Our testimony today will address four areas:

1. current problems in Medicare physician payment,
2. beneficiary out-of-pocket liability for physician services,
3. options for reforming Medicare's current method of paying physicians, and
4. AARP's views on the extension of the 15-month freeze on Medicare payments to physicians.

Current Problems in Medicare Physician Payment

Physician expenditures which in 1983 totalled \$76 billion (an amount representing 22% of national health expenditures) have risen by 13% per year since 1971. Growth in Medicare expenditures for physician services has been even more rapid; between 1980 and

1983, such payments rose by 20% annually for a total expenditure in 1983 of \$14 billion.

Like the Hospital Insurance Trust Fund (HI or Medicare Part A), the Supplementary Medical Insurance Trust Fund (SMI or Medicare Part B) is heading for financial disaster. Part B is the fastest growing federal domestic program with expenditures projected to grow by 16% per year. And while the general revenue financing to the SMI program protects it from insolvency, the rapid infusion of general revenues into the SMI program to meet rising expenditures strains the federal budget deficit.

While prices for physician services have been increasing at nearly twice the rate of general inflation, price alone cannot explain the rapid increases in Part B expenditures. Increasing "intensity of services", as measured by the number of services per enrollee, represents another important contributor to rising Part B costs. Between the 1980 - 1982 time period, increasing intensity accounted for nearly 40 percent of the growth in the Part B program. Any reform in payment policies will have to address not only price increases, but also volume increases.

Beneficiary overuse cannot be linked to increasing Part B expenditures. No study has ever demonstrated excessive or inappropriate use of medical services by the elderly. Each year only 60 percent of beneficiaries use reimbursed physician services. Moreover, the elderly's per capita visits to physicians have remained stable at about 6.5 visits per year since 1970.

It is now generally understood that Medicare's physician reimbursement system which is based upon what physicians customarily charge each year (the CPR methodology) encourages physicians to set

higher prices and deliver more services, even though such prices and services may not be warranted in terms of costs and medical appropriateness. Moreover, the CPR methodology has generated numerous discrepancies and anomalies in physician payment such as:

- The gap in compensation for the use of technology and procedures over cognitive services;
- Differentials in reimbursement by specialty, place of service, and geographic location;
- The presence of payment incentives that discourage the treatment of the sickest and frailest segments of the population;
- The presence of payment incentives that encourage the use of expensive hospital care over less costly office-based care.

Beneficiary Liability for Physician Services

While Medicare coverage for hospital services is fairly comprehensive, Medicare coverage for physician services (both in-hospital and out-of-hospital) is less than adequate. Under existing law, Medicare beneficiaries have substantial liability for the cost of physician services. Beneficiaries pay:

1. An annual Part B premium, which will total \$186 in 1985 and has risen 116% since 1977;
2. An annual Part B deductible currently \$75 which represents approximately \$100 in actual out-of-pocket costs since only Medicare "allowable" charges count towards the deductible and the Medicare reduction rate (the amount by which actual charges are

- reduced by Medicare) is currently 24%;
3. Twenty percent coinsurance of Medicare's "allowable" charges for services which has doubled over the past five years; and
 4. Charge reductions associated with unassigned physicians' claims which totalled \$2.5 billion in 1983 and has risen by over 200% in the past five years.

As a result of these charge components, beneficiaries are now responsible for over 60 percent of total physician charges due under Part B.

Under current law a physician may accept or refuse assignment on a bill-by-bill basis. If he agrees to "accept assignment," he agrees to accept Medicare's reasonable charge determination (20% of which the patient must pay) as payment in full. If the physician refuses to accept assignment, the patient is liable for the same 20% plus the difference between Medicare's reasonable charge and the physician's actual charge.

Approximately 56% of all Part B claims submitted to Medicare for reimbursement at this time are "assigned" compared to less than 50% in 1977. AARP is pleased to note the increase in the assignment rate over the past several years. Nevertheless, beneficiary liability for "unassigned" claims has increased substantially in the past several years, eroding the insurance protection available under Part B for the cost of physician care.

In the absence of comprehensive reform in physician payment, the Association approaches the issue of mandating Part B assignment with caution because of the risk of diminishing the current

56% physician assignment acceptance rate. The Association supports legislation that provides: (1) financial and administrative incentives such as streamlined billing to encourage physicians to accept assignment; (2) "participating" physician programs like those contained in the Medicare Physician Fee Freeze; (3) and the development of regional or local directories that identify physicians who accept assignment. The Association notes with approval HCFA's decision to publish assignment data and has urged HCFA to distribute the information widely in a usable format.

Public and private payments for physician services provided to Medicare beneficiaries now account for almost one-third of total physician expenditures; moreover, Medicare reimbursement to physicians represents on average nearly one-fourth of physician income. Mindful of these factors, the Association supports mandatory assignment but only as part of a more comprehensive payment system for physicians that establishes rational and fair reimbursement rates.

Physician Payment Reform

Last year Congress took an important first step towards addressing the complex problem of rising physician fees when it enacted the Medicare physician fee freeze. AARP believes that Congress should build upon this initiative and this year enact legislation which would serve as the basis for the institution of a more rational physician payment methodology, beginning in 1987. AARP believes that no one payment methodology (DRGs, fee schedules, capitation, etc.) will be appropriate for all types of physician services. While AARP does not endorse at this time a particular

mix of payment mechanisms, AARP would like to suggest a number of proposals that could comprise a legislative package for long-term physician payment reform. Modeled after the legislation (The Tax Equity and Fiscal Responsibility Act of 1982) which led to Medicare reform of hospital payment, the proposals include:

1. The establishment of a set of physician services, defined by the Secretary of HHS, to which weights would be assigned. In assigning weights, particular attention should be given to correct the current discrepancy in payments such as the gap in compensation between care and cognitive and primary care services.
2. The development of a standard amount by which to convert the service weights to fees. The standard amount should be indexed to allow updates by a measure of inflation in future years.
3. The incorporation of a transition period so that the move to the new payment rates would be gradual and predictable.
4. A mechanism for regular recalibration and reconsideration of service definitions, including a methodology to adjust payments as the cost of technology and services change over time.
5. A mechanism to adjust payment by severity of illness in order to prevent discrimination against care of the frailest segments of the population.
6. A national decision of whether and how much specialty should affect the payment rate, and if so, the establishment of a national definition of specialty.

7. An allowance for geographic variation in payment related to costs in the geographic location where the service is provided.

AARP believes that it is essential for Congress to consider long-term reform of Medicare Part B. AARP certainly recognizes the federal budget problem associated with rapidly rising Part B expenditures. However, AARP believes that program savings alone cannot serve as the sole criterion for changes in Medicare Part B. Therefore, if Congress finds it necessary to implement measures to curtail Part B spending growth in FY '86, AARP recommends the following alternatives to a flat fee freeze which would not only produce savings, but also begin to redress current discrepancies and anomalies in Medicare physician payment:

1. A freeze only on Part B services rendered to hospital inpatients.

This measure would produce substantial budget savings since two-thirds of Part B's total allowable charges go for inpatient physician care. Moreover, this option would reduce the financial incentive to select expensive inpatient care by redressing the current payment differential between in-hospital physician services and office-based care.

2. A freeze only on higher cost services or a freeze on all services except those services - primarily cognitive or primary care in nature - that are currently undervalued compared to procedure-oriented services.

AARP recognizes that many physicians continue to provide valuable primary care services and services which

are cognitive in nature, even though current payment schemes penalize them for the use of these services rather than the use of procedure-oriented services. These options would produce budget savings while allowing reimbursement for those services which have been undervalued over time to rise.

3. A limit on high fees within each service code.

A limit on high fees by service would reduce geographic variations in payment which seem to defy those that could be considered reasonable due to cost-of-living variations. For example, in 1980, the ratio between the highest prevailing charge (\$33.10) and the lowest prevailing charge (\$7.00) for a brief follow-up hospital visit was 4.73:1. For a chest x-ray by a radiologist, the ratio was 6.36:1.

The Proposed Extension of the 15-Month Freeze on Medicare Physician Payments

In recognition of the problem of rapidly rising Medicare expenditures for physician care, Congress enacted a freeze on Medicare payments to physicians as part of The Deficit Reduction Act of 1984. AARP supported the freeze provision because the freeze provided a temporary, but necessary restraint, on rapidly escalating physician fees and contained protection for older persons against the rising cost of physician care. In addition, the freeze provided clear incentives to encourage the acceptance of Medicare assignment.

This year Congress has been considering proposals to extend

the current freeze on Medicare physician payments for another year. As a result, Medicare's allowed charges for physician reimbursement would be frozen for a total of over two years. While there are strong budgetary reasons for supporting such an extension, AARP believes that a simple extension of the freeze would cause significant problems for both beneficiaries and the Part B program.

First, a drop in the assignment rate.

The current fee freeze allowed physicians to choose a "participating" (accept assignment in all cases) and "non-participating" (accept assignment on a case by case basis) option. As an incentive, "participating" physicians were allowed to pass along higher charges to be added to their record during the freeze period in order to receive more generous Medicare reimbursement when the freeze expired. Thirty percent of physicians have elected to become "participating" under the current freeze, a 10 percentage point (or 50% increase) over the previous 20% who agreed to accept assignment in all cases. Extending the freeze would break faith with these "participating" physicians by denying them their promised update in Medicare fee screens. The likely result is a drop in the participation rates and higher costs to beneficiaries.

Moreover, the assignment acceptance rate (which, we are pleased to note, has been significantly increasing over the past year) would likely drop. Sixty-nine percent of the physicians responding to a 1982 survey by the American Medical Association identified inadequate Medicare reimbursement as an important reason for there not accepting assignment. In 1971, President Nixon froze wages and prices (including physicians' fees) under the

Economic Stabilization Act (ESA). Between August 1971 and April 1974, while ESA was in force, the physician assignment rate fell more than eleven percent.

Second, higher costs to beneficiaries.

The current freeze also contained a freeze on actual charges by "non-participating" physicians in order to prevent a widening disparity between physicians' actual charges and Medicare allowable charges which could be passed on to beneficiaries during the freeze period. A more than two-year freeze without adequate safeguards against higher actual charges would significantly widen the gap between Medicare allowable charges and physician actual charges, thus exposing beneficiaries to further cost-shifting. Assuming a 7% annual increase in physician fees for two years, an actual charge which has been frozen at \$100 would rise to \$114.50. If the Medicare allowable charge is \$75, the difference between the actual charge and Medicare allowable charge would increase from \$25 to \$39.50, a 58% increase in beneficiary liability associated with the charge reduction for this fee. This increase in out-of-pocket costs would be in addition to the beneficiary coinsurance and deductible.

Third, higher Part B expenditures.

While Congress is looking to a continuation of the fee freeze as a means of budgetary savings, a prolonged freeze may have the opposite effect. Despite the price freeze during ESA, overall physician expenditures rose substantially because of a large increase in the volume of services provided. If physicians circumvent a prolonged freeze by increasing the volume of services, even higher government expenditures for physician care could

result.

Fourth, the development of a two-tier system of care.

The gap between the percentage of the physician fee covered by Medicare and the percentage covered by private plans has already been widening. For example, for a follow-up office visit, Medicare covered 67% of the fee and Blue Shield plans covered 71.3% in 1979, for a gap of 4.3%. By 1983, this gap had widened to 9.4%, with Medicare covering 68% of the fee and Blue Shield plans covering 77.4% of the fee. Proposals such as a prolonged freeze, which would widen this payment disparity even more, subject the elderly to the possibility of receiving less adequate care than that provided to the rest of the population.

Conclusion

Well-documented problems in Part B expenditure escalation and payment inequities illustrate that reform of Medicare Part B is long overdue. AARP looks forward to working with the Congress to establish a more rational and fair approach for paying physicians that would encourage the delivery of cost-effective care by physicians and protect beneficiaries against ever-increasing out-of-pocket medical expenses.

Mr. WAXMAN. Mr. Hutton.

STATEMENT OF WILLIAM R. HUTTON

Mr. HUTTON. I am William R. Hutton, executive director of the National Council of Senior Citizens, and we represent 4.5 million senior citizens in some 4,500 clubs across America.

Although it is described as voluntary, part B medicare is a crucial component of the elderly's health insurance coverage. It is the financial vehicle which provides most seniors with access to the health care system, so this is a very, very important subject for us, Mr. Chairman.

Part B reimbursement policy affects senior citizens' out-of-pocket medical expenses, and their access to physician services, and part of this access has been described as financial, and some of it is related to physicians' attitudes toward the Medicare Program.

Reform of part B reimbursement is one of the greatest needs in the Medicare Program today. Public financing of health care using a blank check fee for service method is inflationary, inefficient and wasteful.

Congress recognizes this with the part A program through enactment of the DRG Program. Congress acknowledges that the means to control program spending is to institute reimbursement reform, to stop open-ended payments through a prospective system, and to give providers incentives to operate efficiently.

The same objectives must be applied to part B. Since reform is vital, but not imminent, the National Council of Senior Citizens recommends that Congress be very judicious in its approach to medicare savings in the interim period.

Any changes in part B should be steps that would facilitate future reform rather than obstruct movement in that direction.

For example, increasing the out-of-pocket expenses of the medicare beneficiary will not alter the factors causing part B cost growth, the inflationary reimbursement system, and lack of cost containment throughout the health care system.

Freezing physicians' fees only limits per-unit service. I have been coming before this Congress for 23 years testifying on behalf of the Medicare Program. I don't very often find myself agreeing with doctors in this kind of testimony, but today, on this issue, I feel very much as they might feel, because I know it is going to hurt older people.

That freeze will certainly hurt our older people in the long run. Freezing physicians' fees does not reform reimbursement. It artificially depresses prices, but it doesn't control costs, or doesn't control utilization of service.

A freeze extension could reduce the elderly's access to physicians. Now, if, from what we have heard this afternoon and this morning, if the participating physicians—and we are very concerned about those participating physicians—and you have stressed how they have been led on into the program, encouraged and then kind of taken up the garden path and stranded—if they could be encouraged by being permitted an increase, I think we would gladly support some of the changes which we have heard today, such as including certain inpatient services, extending the freeze

for higher-priced services, and offering various fluctuations, but only if those participating physicians are rewarded, because it is a terrible breach of promise, almost as bad as the breach of promise we are currently suffering from the Social Security COLA.

Whether or not Congress extends the freeze, important questions should be answered. Are the freezes and the participation program achieving their goals? Are physicians complying? How are beneficiaries affected?

Is utilization increasing? Are physicians building practices to maintain income? Are they changing them? The Health Care Financing Administration should be collecting and providing the data to answer these questions, and we encourage the committee to seek information from HCFA which document more than the amount of money the freeze is saving, monitoring the evaluation of physician practices under the programs, identification of violations, and application of penalties are all essential.

Beneficiaries obviously have got to rely on the physician compliance and official monitoring. Medical reimbursement and physician billings are complicated enough for the average recipient to understand. Knowing whether or not one is being overcharged, actually knowing when they are charging more than they should, is a tough proposition for most of our older people.

Whether a service is necessary, extremely difficult. If few complaints are heard from the elderly during the freeze, it is in no way to indicate that the system is working. We just have not got enough facts and figures.

The committee now faces two very great tasks: One, to deal with the immediate problems of the Federal deficit, and the other is to reform payment to patients. We recommend Congress not accept any budget proposal to shift the cost to beneficiaries, discouraging physicians from caring for Medicare patients.

I mean, if you don't reward them for joining the party, then that is a very sad deal.

We believe that the problems of future reform expected to be solved will be even greater than they are today. I hope that you have a great deal of help, sir.

Thank you.

[Testimony resumes on p. 750.]

[The prepared statement of Mr. Hutton follows:]

Medicare Reimbursement of Physicians

Statement by

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925 15th Street, N.W.
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before the

Subcommittee on Health, and the Environment
U.S. House of Representatives
Committee on Energy and Commerce

April 26, 1985

Mr. Chairman, I am William R. Hutton, Executive Director of the National Council of Senior Citizens. The National Council represents over 4.5 million of the nation's elderly persons through over 4,500 clubs and state and area councils throughout the country. The majority of our members are Medicare beneficiaries. Therefore, we appreciate the opportunity to comment today on what is becoming an increasingly important Medicare issue: the reimbursement of physicians.

The methods used for physician reimbursement, the adequacy of payment, and the incentives created by the system are of vital concern to our members. Although it is described as "voluntary," Part B Medicare is a crucial component of the elderly's health insurance coverage. It is the financial vehicle which provides most seniors with access to the health care system. After all, it is the link between senior citizen and physician which enables the senior to receive services ranging from a prescription drug to a routine office visit to hospitalization for acute illness.

The elderly need to purchase Part B coverage and they use this coverage. Because Part B covers primarily physician services both in and out of the hospital, as well as other out-patient care, its utilization across the elderly population exceeds that of Part A, Hospital Insurance. Ninety-eight percent of people over age 65 purchase Part B coverage. Approximately 70 percent annually incur expenses reimbursed by the program. (About 25 percent need to use Part A.)

Part B reimbursement policy affects senior citizens' out-of-pocket medical expenses. The current inflationary policy has unnecessarily increased these expenses. Whether or not they need to use benefits, enrollees must pay the premium, now \$186 per year, or \$15.50 per month. The premium level and its annual increases are directly related to program costs. When services are reimbursed, the elderly patient is required to pay a 20 percent co-payment and excessive charges if the physician does not accept assignment.

The elderly's access to physician services is also affected by Part B reimbursement policy. Part of this access is financial; some of it is related to physicians' attitudes toward the Medicare program and consequently the Medicare patient. The rising cost of service and non-acceptance of assignment create financial barriers for many seniors and may limit their access to a range of physicians. In addition, how the physician perceives the adequacy of compensation for providing service to Medicare patients, and whether or not he/she formally participates in the program may affect a physician's willingness to accept Medicare patients.

Today's hearing is a very timely one. It occurs on the eve of Medicare's 20th anniversary: an opportunity not only to celebrate the program's success, but also to evaluate whether or not it is fulfilling its purpose or reaching the goals set 20 years ago. The hearing is also taking place at a time when Part B program costs are sharply increasing, financial burdens on the beneficiaries are growing, and the Federal deficit is pressuring Congress to enact shortsighted budget cutbacks which shift additional costs to beneficiaries and fail to control spending in the long term.

In this environment, we should be asking: What has happened over the 20 years of Medicare? Where are we now? What is right and what is wrong? What should be changed? What should be preserved or strengthened?

This is not really a monumental task, although it is one which will take some time, but thoughtful analysis and institution of effective reform need time. A look at Part B Medicare, with a particular view toward reimbursement of physicians, is a good place to start.

If we consider two decades of supplementary medical insurance, it is apparent that a great deal of change has occurred over the 20-year period. The nature of medical practice, development and growing use of technology, increasing specialization, and expanding populations of both physicians and the aged have very significantly contributed to these changes. To an extent, the program has been adapted to these changes.

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However, a major element of the program has not been altered to these changes--the reimbursement system. This failure, coupled with other factors pushing up the price of medical services and total spending on health care, now seriously threatens Part B's benefit adequacy, the program's financing, and the Medicare beneficiary's health and income security.

Mr. Chairman, reform of Part B reimbursement is one of the greatest needs in the Medicare program today. Public financing of health care using a "blank check" fee-for-service method is inflationary, inefficient, and wasteful. Congress recognized this under Part A. Payments to hospitals have accordingly been reformed through Diagnosis Related Groupings (DRGs). Although the impacts of DRGs on quality, on beneficiaries' welfare, on cost shifting, and on overall Medicare outlays have not yet been evaluated, one thing is apparent: Congress acknowledged that the means to control program spending is to institute reimbursement reform, stop open-ended payments through a prospective system, give providers incentives to operate efficiently, and place the financial risk on providers, not the patients.

The same objectives must be applied to Part B where reform is long overdue. The National Council of Senior Citizens acknowledges that studies are being conducted to determine which prospective payment methods might be effectively applied to physician services. We also recognize that the Committee will hear testimony from several witnesses with technical expertise on reimbursement methodology. Therefore, I will provide the Committee with comments from the beneficiaries' perspective concerning problems

under today's system, including the effects of short-term budgetary changes on Part B, and comments concerning possible reform alternatives.

Since Part B reimbursement reform is vital but not imminent, the National Council of Senior Citizens recommends that Congress be very judicious in its approach to Medicare "savings" in the interim. Any changes in Part B should be steps that would facilitate future reform rather than obstruct movement in that direction. To illustrate, I will discuss some of the recently-enacted and proposed changes in the Supplementary Medical Insurance Program. These changes have been made or proposed for the purpose of slowing Part B outlay growth.

1. Increases in Beneficiary Cost Sharing Levels

- Beneficiary cost sharing levels are already very high. In 1984, the elderly paid out of pocket an estimated \$17 billion for the Part B mandated premium and deductible, the Part A deductible, co-payments, and physicians' fees in excess of assigned rates.
- In four years the Part B premium has increased by 62 percent (from \$115 to the current \$186 per year), due to budget reductions and growth in program costs. The deductible was increased by 25 percent (to the current \$75) in FY 1982.
- Part B coverage is expensive and severely incomplete. Enrollees pay \$261 (premium plus deductible) out of pocket in order to be reimbursed. When reimbursement does occur, it pays on average just over half of physicians' billings.
- Between budget cuts which have shifted additional financial burdens to Medicare beneficiaries and medical inflation which is still growing at faster rates than the CPI, older people now expend a portion of their incomes equal to that before Medicare "protection" was enacted.

- Increasing the out-of-pocket expenditures of the Medicare beneficiary will not alter the factors causing Part B cost growth--the inflationary reimbursement system and lack of cost containment throughout the health care system.
- Continuing to shift Part B costs to the elderly will reduce their financial access to physician services and allow program costs to escalate further. In addition, this cost shifting could discourage use of lower-cost alternatives to hospital care and timely visits to physicians. Part A costs may increase as a result. We believe that these factors will make effective reform that much more difficult to achieve.

2. Freeze physician reimbursement levels.

- By enacting the freeze in 1984, Congress recognized that physicians' fees and financial incentives are a major factor in Part B outlay growth. However, a freeze is only a limit on payment per unit service. It is not reimbursement reform; it does not control utilization or provide incentives for efficiency. In the long run, the freeze could be counter-productive for the Medicare beneficiary's access, physician participation, and control over program costs.
- The freeze artificially depresses prices but does not control costs. While prices are fixed, physicians can maintain or increase income by providing more units of treatment or more intensive services. Thus, the total costs to the government and the beneficiary may actually increase.
- Continuing the freeze could discourage physicians from seeing Medicare patients, a totally undesirable outcome of public policy.
- If "participating" physicians who signed agreements to accept assignment on all Medicare cases are not excluded or otherwise protected; they cannot be expected to renew their contracts; additional participation should not be expected to occur.

At this point, I would like to make additional comments about the freeze and physician participation program. Whether or not Congress extends the freeze, important questions should be answered. Are the programs achieving their goals? Are physicians

complying? How are beneficiaries affected by the programs? Is utilization increasing? Are physicians changing billing practices?

Most of the answers should be available through Health Care Financing Administration's collection and use of data. The completeness of the answers, however, depends on the information the HCFA provides. We encourage the Committee to seek information from HCFA which documents more than just the amount of money saved. It is critical that monitoring and evaluating of physicians' practices under the freeze and the participation program are being conducted thoroughly and that violations are both identified and dealt with according to the law.

The beneficiary under the freeze must rely on physician compliance and official monitoring. Medicare reimbursement and physicians' billings are complicated enough for the average recipient to understnad. Knowing whether or not one is being overcharged or whether a service is unnecessary is extremely difficult. Therefore, we suggest that if few complaints are heard from the elderly during the freeze, it in no way indicates that the system is working.

Regarding the participation program, we believe it is an important step toward increasing assignment levels. In addition, the directories provide the elderly with valuable information to help them select physicians. However, neither the participation program nor the directories should be considered solutions to the problem of non-assignment. Assignment rates are still very low and unevenly distributed throughout the country. These problems

can be dealt with through reimbursement. If payment rates under a reformed system are equitable and perceived as adequate, we believe that mandatory assignment would be acceptable to most physicians.

We have received comments and complaints from our members concerning both the freeze and the participation program. Support for the contention that physicians might comply with the freeze but increase units of service or alter billing practices has been reported. Some of our members have told us that their physicians now bill for writing drug prescriptions or renewing prescriptions, whether or not an office visit is involved. In addition, many members trying to use the directories of participating physicians report that inconsistent or apparently false information is published. For example, physicians who are hospital residents are listed; physicians who refuse to take assignment for office visits are listed; and entities which do not appear to be groups of practicing physicians are also listed. Not only does this information artificially inflate the apparent levels of participation, it defeats the purpose of consumer information. We have discussed these problems with representatives of the Health Care Financing Administration. We urge the Committee to pursue the matter as well.

The Committee now faces two very great tasks. One is to deal with the immediate problems of the growing Federal deficit through the fiscal year 1986 budget. The other is longer-term, to reform reimbursement to physicians. Although we expect that the Congress will deal with these issues at two distinct time periods, the issues are not necessarily totally separate. The proposals that are adopted for short-term budget savings will affect the long-term as well. Both pragmatism and incremental

policy development suggest that Congress could begin its approach to physician reimbursement reform in FY 1986.

One of the methods we suggest is, in fact, avoidance. We recommend that Congress not accept any budget proposal which would simply shift costs to beneficiaries, discourage physicians from caring for Medicare patients, or allow Part B costs to escalate without control. Otherwise we believe that the problems that future reform will be expected to solve will be even greater than they are today.

Therefore, I repeat the comments NCSC made before the House Ways and Means Committee during last week's hearing on the FY 1986 budget:

- The causes of the Federal deficit and the savings meant to retard its growth should not be sought in the Medicare program. Look at the President's fiscal spending priorities for the solutions to the deficit problem.
- We urge you to seek carefully thought-out savings for Medicare, not arbitrary budget reductions which place beneficiaries at risk and give providers incentives to reject Medicare or "game" the system. This method negates the savings or jeopardizes the health of senior citizens. We have had enough of this method over the last four years.
- The entire health care system needs the attention of Congress. We believe that the most desirable and most equitable savings in Medicare will be achieved through health system reform and Medicare reimbursement reform. Long-term savings and equity will not be achieved unless Congress gives providers the incentives toward economic efficiency by placing them at risk in the payment system.
- The National Council of Senior Citizens supports the Kennedy/Gephardt proposal, Medicare Solvency and Health Care Incentives Reform Act of 1985. It assures savings without benefit cuts, changes provider incentives, rewards efficiency, and builds a nationwide system of health cost management. We urge the Committee to seriously consider such a plan.

- Plans to add new revenues to the Medicare trust funds are frequently discussed as a way to deal with the financing of the program. We urge you to consider that new financing and cost control or incentives for efficiency are not analogous. They may all be necessary at some point, but we suggest that new revenues not be sought without total system cost containment. Otherwise we will simply be adding money to the problem while allowing costs to grow for the same reasons they are today.
- In the meantime, we ask you to look at Part B reimbursement reform to control outlays rationally and fairly without penalizing either the providers or the recipients of care.
 - ° We do not believe that extension of the freeze meets these criteria unless participating physicians are exempt. Even with an exemption, a partial freeze must be viewed strictly as a temporary measure to allow time for developing a prospective payment plan to replace the current system.
 - ° If the freeze extension is rejected, we recommend that total savings from Medicare be reduced rather than shifting additional expenses to beneficiaries.

The need for Part B reimbursement reform is intensifying because years of inflationary pressure have escalated cost growth to an alarming degree. In addition, recent changes in Medicare law and regulation are shifting new costs to Supplementary Medical Insurance Program: DRGs are reportedly shifting some costs from Part A to Part B since unnecessary hospitalization is being discouraged; Peer Review Organizations (PROs) are also identifying increasing numbers of procedures which must be performed on an out-patient basis.

There are many potential plans for physician reimbursement reform. As the Committee considers the merits of each proposal and the technical advice that experts provide, the National Council of Senior Citizens recommends the use of these guidelines:

- Reform should institute a prospective method of reimbursement with limits on total costs or price per unit, and monitoring of quality and utilization.
- Savings, or slowing outlay growth, is only one goal of reform.
- Preservation of access and limitation of beneficiary cost-sharing liability growth are vital goals of reform.
- Reform should be fair to beneficiaries and to providers.
- The financial risk under a new reimbursement system should be borne by the provider.
- Reform should require physicians to accept Medicare rates as payment in full.
- Compensation levels for providing services to Medicare beneficiaries must not discourage physicians from participating in the program.
- Access to medical service for all beneficiaries must not be compromised by reform.
- Inequities of the current reimbursement system, for example, overcompensation and undercompensation for certain services, or geographical variations should be reduced through reform.

We appreciate this opportunity to participate in what will be only one of many discussions of reimbursement reform. We look forward to working with the Committee and staff in the future as proposals are more clearly defined.

Mr. WAXMAN. Thank you very much.

I want to commend both of you for your testimony today. We don't really know what is happening with the current freeze. We have some guesses. Are you getting any feedback, either of you, from your members about the current freeze? Are they having problems with access? Do the directories seem to be useful?

Dr. GILMOUR. I do not have myself a great deal of access to what the AARP gets at their headquarters here because I don't live here with them. With me is Chris McEntee, legislative representative from the AARP. Have you gotten much information of that type, Chris?

Ms. McENTEE. In reference to that first point on whether we heard a lot about access problems or violations of the freeze, we have not, but I wouldn't take that as a conclusion because as Mr. Hutton said, payment under part B is so confusing even before the freeze for the beneficiary to understand and we have always heard complaints about that, that I am not so sure a lack of hearing complaints is any suggestion of what real problems are going on out there.

But the second point about access to the directories we have heard some problems of beneficiaries being able to get that information. The publication of the directories was late and didn't come out—I understand many of the directories didn't reach our members until maybe just last month.

Second, there has been increasing problems with beneficiaries going to the associate security offices and not being able to copy the pages for their community to be able to get that information.

Mr. WAXMAN. That is very peculiar.

Mr. HUTTON. Mr. Chairman, the threat of cutting back Social Security employees which looks very, very real, is another thing which we are faced with in the future. At the moment, it is very difficult, we are very aggressive about this, and that does help, but if you are short of staff, all the aggression in the world won't get you the answers.

Mr. WAXMAN. Are you concerned about simply lifting the freeze, letting it expire and what that means in terms of the jump in prices that will be charged to the elderly under Medicare for their physician services potentially?

Dr. GILMOUR. We are greatly concerned about that because if it expired without any change in the methods of payment which are now in effect, it would be I think very expensive, very adverse to the beneficiaries because both participating and nonparticipating physicians would be involved and therefore the beneficiaries costs would go up.

We cannot say how much but it would be considerable.

Mr. WAXMAN. How do you suggest we deal with that?

Dr. GILMOUR. I think that in extending the freeze, it has to be associated with some of the alternatives which I suggested and which others I notice today have suggested, too. Including the freeze only for hospital bed patients, maybe adjustments for certain types of costs as compared to others, the underpriced and overpriced costs, and things of that sort.

In other words, the freeze continues, and I think what has to be included with that is some adjustment in the way all Medicare patients are paid.

Mr. WAXMAN. The use of the freeze selectively and release in certain areas, won't you find big jumps in prices then?

Dr. GILMOUR. I don't believe if you had it selectively in those general areas. I think you would have some jump because patients have been behind, clinics and doctors have been behind in their costs. One clinic I just talked to yesterday, costs have gone up 9 percent this year of course fees have been frozen. That is something that they have to take into consideration because their suppliers are not frozen, the nurses are not frozen, utilities are not frozen, rent is not frozen, so that does make a difference.

Mr. HUTTON. After the voluntary freeze costs went up last time, you know. I think the Congress has a very difficult task. You are damned if you do and damned if you don't in the question of the freeze.

I think the best solution is a qualitatively constructed continuation which will help the program along. I know it is hard to find out, but it just cannot be done to save money. The budget itself, budgetary changes have never been successful and they never will be.

Mr. WAXMAN. Mr. Hutton, you seem to say that when we put a freeze on some of these selective areas or even reduce payment, if you accept that, that we should have a mandatory assignment coupled to it.

Mr. HUTTON. Oh, yes, I prefer that.

Mr. WAXMAN. You seem to disagree, Dr. Gilmour.

Dr. GILMOUR. Yes.

Mr. WAXMAN. Are you afraid of it being passed on?

Dr. GILMOUR. I would disagree strongly with the mandatory assignment because I think that it has some dangers inherent in it. I do think if the selective freeze is continued it should also be selective with some protection for beneficiaries and that would have to be worked out in detail.

Mr. WAXMAN. How would you do that?

Dr. GILMOUR. There would have to be a limit on what in the freeze could be raised.

Mr. WAXMAN. Similar to what we are doing now?

Dr. GILMOUR. Yes.

Mr. WAXMAN. Price controls.

Mr. HUTTON. I think payment would have to be accepted as fair before you introduced mandatory assignment.

Mr. WAXMAN. Well, I thank both of you very much. I think it has been very helpful to get your views on the record and to help us think through what options we might want to take as we deal with this issue.

Thank you very much.

Dr. GILMOUR. It is a privilege to be here and it is very interesting to hear all that went on this morning.

Mr. HUTTON. Thank you very much, Mr. Chairman.

Mr. WAXMAN. That concludes our business for today. We will stand adjourned.

[Whereupon, at 1:25 p.m., the subcommittee was adjourned.]

[The following statements were submitted for the record:]

VIEWS OF

THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

The American Academy of Family Physicians is taking this opportunity to submit comments on the Medicare Budget issues being studied by this subcommittee. We appreciate the concern of the subcommittee members in considering the impact of the President's proposed budget for Fiscal Year 1986 on Medicare providers and beneficiaries. We are well aware of the difficult task before Congress this year in reducing an enormous federal deficit, but are encouraged by this subcommittee's efforts to consider the possible effects of these cuts.

As the Administration and Congress seek to reduce federal expenditures, again they look at the Medicare program for a large portion of the savings. Medicare has been and continues to be a natural target because of the sizable program expenditures. We wish to caution the subcommittee that for this reason, Medicare has also been a major factor in shaping America's health care delivery system, affecting the way medicine is practiced, how providers are reimbursed and who will practice medicine. As Congress looks at the various proposed ways to cut the budget, it is more imperative than ever that federal funds are expended in such a way as to do the most good for the greatest number of people--that short term budget cuts do not take precedence over long term policy implications. The Medicare proposals in the proposed Administration and Senate budgets will have a significant impact on family physicians and their patients.

The AAFP is opposed to the freeze extension on physician Medicare reimbursement and fees proposed in both the Administration and Senate budgets. Last year Congress passed the Deficit Reduction Act of 1984 which included a freeze on physician's customary and prevailing charges for fifteen months at 1982 levels. The freeze was intended to reduce Medicare expenditures, while providing incentives for physicians to become "participating physicians" in the Medicare program. The major incentive was that participating physicians would be allowed to increase their billed charges, with the promise that at the end of the freeze, adjustments would be made in participating physicians' customary charges based on those increases in their billed charges during the freeze.

The American Academy of Family Physicians, along with the American Medical Association, wholeheartedly endorsed a one year voluntary freeze that ended in February 1985, which involved nearly 80% of all physicians and was estimated to have saved approximately \$1.5 billion. Furthermore, the Academy continues to urge its membership to give special consideration to cases of financial hardship on a patient-by-patient basis. Physician's willingness to contribute to deficit reduction has been demonstrated.

The American Academy of Family Physicians believes, however, that a fee-freeze extension is contrary to sound national health policy and may reduce access to medical care

for the elderly. As the cost of practicing medicine continues to escalate and reimbursement falls behind, we are concerned by the very real possibility that an increasing number of physicians may choose not to accept Medicare patients. Another unintended result may be increased cost of medical care for non-Medicare patients.

The fee freeze has different implications for different specialties, as well as different individuals within a specialty. Figures recently released by the Health Care Financing Administration indicate that 29.4% of all physicians participating in the Medicare program have signed agreements to become participating physicians. The participation rate for "general practitioners" is shown as 27.3% and the rate is 25.5% for family physicians compared, for example to 41.3% for radiologists and 50.89% for nephrologists. What these figures don't show, but suggest, is that there is an inherent inequity in the current Medicare reimbursement system, which emphasizes costly, inpatient, procedurally-oriented care and which generally provides less reimbursement when provided by a general practitioner or a family physician than when the same service is provided by some other type of specialist.

Indeed data provided by the AMA Socioeconomic Monitoring service indicate that from 1982 to 1983 all physicians experienced an increase in net income of 6.8%, while family physicians/general practitioners experienced a decrease in net income of 4.7%. During that same time, medical specialties

had an increase in net income of 4.8% and surgical specialties increased 9.6%. The data further reveal that the median income for all physicians in 1982 was \$85,000 compared to a median income for general practitioners/family physicians of \$63,000. In 1983 the median income for all physicians was \$45,000, compared to \$40,000 for general practitioners/family physicians.

Congress initiated a study of the reimbursement problem in last year's Deficit Reduction Act. As a result, the Office of Technology Assessment is currently studying several issues surrounding Medicare payment to physicians, including the differential in Medicare payment for cognitive services as compared to procedural services. It is hoped that the finding of the OTA study will provide the impetus for a resolution in the inequities that exist between reimbursement levels for procedural versus cognitive services. Such changes in the Medicare payment system would make Medicare assignment more attractive for family physicians and also be beneficial in assisting family practice residency programs to generate a greater percentage of revenues from patient care income.

Extending the fee freeze, however, unfairly perpetuates the existing inequities in Medicare reimbursement. It penalizes those physicians whose reimbursement under Medicare was already inadequate before the freeze went into effect. The primary role of family physicians as patient advocates is being jeopardized by economic realities. And, as new graduates of medical schools look at this situation and the impact on their futures, less are choosing the specialty of family practice. This will have a detrimental effect on the nation's health care delivery system.

The AAFP believes that the proposed budget cuts in Medicare should be carefully evaluated and their effects on the quality of health care and continued access to providers considered. Medicare beneficiaries ultimately will bear the brunt of the cuts if quality and access cannot be ensured. Our nation's health care delivery system continues to be shaped by your decisions. Your consideration of this issue and our comments is appreciated

STATEMENT OF
THE AMERICAN OSTEOPATHIC ASSOCIATION

Mr. Chairman and distinguished members of the Committee, the American Osteopathic Association (AOA) appreciates this opportunity to present testimony on the subject of physician reimbursement. We recognize that your immediate focus, and the focus of much of today's testimony, is on short-term issues. We know, however, that the Committee soon will come to grips with long-term considerations with respect to physician reimbursement. We can think of no issue which has greater potential to profoundly affect access to, utilization of, and the structure of the health care delivery system. For this reason, we believe that careful study, as Congress has directed the Health Care Financing Administration (HCFA), is most appropriate.

In recent months, there has been growing sentiment that the existing Medicare physician reimbursement system should be changed. The American Osteopathic Association agrees with this view. In fact, we believe that this and other challenges faced by Medicare threaten the very intent of the original program. As we see it, there are three very real problems that must be addressed: (1) the program's uncontrollable and unpredictable rate of expenditure growth; (2) increasing confusion shared by both beneficiaries and providers regarding benefit amounts and coverage, and (3) growth in program regulation which interrupts desirable patient-physician interaction.

The American Osteopathic Association has responded to HCFA's call for applications to demonstrate innovative physician reimbursement alternatives. We have submitted a grant application to demonstrate an indemnity system of reimbursement for office-based physician services. The Medicare indemnity benefit would be defined as a schedule of fixed payments for physician services. For a particular set, or "bundle," of services, Medicare would make a fixed payment. Payment would no longer be based upon the current formula of actual, customary and prevailing charges. The schedule of payments would include only a small number of payment categories (e.g. six to 10 levels of office visits), with the level of payment for each category based on the intensity of treatment as determined by the relative values of the component bundled services.

We believe that such a system will:

- o Provide more predictability and the potential for controlling the level of Medicare benefit payments;
- o Reduce the administrative costs of the Medicare Program;
- o Encourage beneficiaries to make a more prudent purchase of medical services;

- o Encourage competition among physicians in terms of service configurations and prices.

These theses will be tested if our proposal is favorably received by HCFA. Whether or not we are competitive in the physician reimbursement demonstration grant process, however, we believe that the concept of indemnity reimbursement belongs in the mix of ideas Congress considers in affecting reimbursement reform.

It is generally recognized that rising expenditures for Medicare benefits result in part from the fact that beneficiaries face relatively weak incentives to limit their own consumption. Furthermore, physicians are encouraged by the current method of reimbursement to deliver as much service as possible.

Attempts to discourage rising levels of Medicare expenditure have generally taken two approaches: To limit physician fees through price freezes and guidelines; or to put physicians at financial risk if they encourage increases in utilization. The former approach is administratively cumbersome and not particularly successful from a historical perspective. The latter is exemplified by health maintenance organizations, which have

achieved some success in restraining utilization. HMOs, however, limit an individual's choice of physician and there remains some doubt whether their favorable performance may be due to favorable selection of members.

The AOA believes the indemnity approach is a positive alternative in assuring a predictable level of expenditure by Medicare. Such a system would be administratively simpler than price guidelines, more amenable to the practices of solo physicians and less susceptible to selection bias among patients. The key to an indemnity system is that it limits to a predictable amount Medicare's reimbursement liability for each physician visit. It encourages patients to seek less expensive or more efficient forms of care. It places greater emphasis on the roles of the patient and the physician in reaching an agreement on the price of services.

One of the greatest problems with the existing payment mechanism is that it pays different prices for the same service. This has two unfortunate effects: Patients are confused about what Medicare will pay; and more expensive or less efficient care is subsidized.

The simplification of reimbursement proposed in the AOA indemnity plan would restore appropriate incentives to both physicians and patients. The plan would achieve this goal by paying a fixed amount for a particular type of physician visit. Patients would be free to assign or not assign this payment to the physician. Physicians would be free in either case to balance bill their patients for any difference between the indemnity benefit and their usual fee.

There are several benefits to this proposal. First, patients will exercise their own judgment about what they are willing to pay for a particular treatment. Those who seek more expensive care will do so at no added cost to Medicare. Patients who seek less costly care will be rewarded by the fact that the Medicare benefit is not decreased. In either case, patients will be encouraged to resume the traditional doctor-patient relationship where fees are subject to individual agreements among the physician and the patient.

Physicians will also be encouraged to provide as much value for the money as possible. The incentive to inflate fees to raise profiles is eliminated since there is a single indemnity payment for a particular service. In addition, each physician will be more conscious of how his fee and service compares to other colleagues.

In summary, we believe the Congress and the Administration will gain desirable advantages as a result of this approach. These include administrative simplicity, precise ability to forecast costs, and a reinforcement of Medicare's original purpose.

We are aware that this proposal is not a panacea for the serious problems faced by Medicare. We do believe, however, that it warrants serious consideration. It is possible, if not probable, that a pluralistic approach, utilizing several alternative schemes, may be most successful in resolving Medicare's problems.

We are convinced that the solution to these problems must be found within the open market philosophy that has existed throughout the history of American medical care. Any new physician reimbursement system will require careful planning and structuring; for some new approaches, intermediate Congressional action may be indicated. For example, the use of relative value scales, either directly, or (as in our proposal) as a part of a reimbursement structure, poses legal questions for which there seem no ready answers. We respectfully suggest that it would be most appropriate for Congress to provide guidance to the Federal Trade Commission as that Agency attempts to advise the medical profession on the anti-trust questions surrounding relative value scales.

The American Osteopathic Association and its member physicians are committed to working with Congress and the Administration in effecting needed reimbursement reform, while ensuring that the finest health care delivery system on Earth remains a strong and viable force in the future. Thank you, Mr. Chairman, for this opportunity to present our views.

STATEMENT OF THE
NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

**CONTROLLING DOCTORS' FEES IS NECESSARY
TO PROTECT MEDICARE BENEFICIARIES**

Introduction

Reacting to strong grass roots lobbying by senior citizens, Congress acted last June to temporarily freeze doctors' fees and reward "participating" doctors who accept the Medicare-determined reasonable charge as full payment for all Medicare beneficiaries. Congress rejected an alternative to freeze only Medicare reimbursements, which would have shifted costs to the beneficiary. This was a major defeat for the powerful doctors' lobby which seems to put the financial welfare of the doctors above the medical welfare of senior citizens.

As a result of the legislation, Medicare Part B premiums rose only 6 percent in 1985 compared to a projected 12 percent without the legislation.^{1/} Perhaps more importantly, copayments and non-assigned fees will remain stable this year. Controlling doctors' fees will continue to be an important issue in 1985. The fee freeze will expire in October 1985, but Congress is likely to extend the temporary fee freeze or enact a permanent cost control program.

During this legislative debate the National Committee to Preserve Social Security and Medicare will continue to argue for mandatory assignment and controls on doctors' fees to Medicare beneficiaries without sacrificing quality of care. This paper discusses Medicare reimbursement of doctors' fees and the evidence in favor of controls.

Pressures for Reform in Medicare Reimbursement

The cost of Medicare has skyrocketed. In recent years payroll taxes for the hospital insurance trust fund have increased more than 40 percent — from 0.9 percent in

1977 to 1.3 percent in 1984, and will rise to 1.45 percent by 1986.^{2/} General revenue appropriations for supplementary medical insurance have increased by more than 50 percent — from 1.3 percent of the budget in 1977 to 2 percent in 1984.^{3/} Outlays for doctors are increasing at a faster rate than outlays for hospitals. According to the Senate Special Committee on Aging, "Hospital reimbursements increased 191 percent and physician reimbursements increased 255 percent [for Medicare between 1976 and 1983], growing at an annual rate of 13.6 percent and 19.2 percent respectively."^{4/}

Health care cost inflation and Medicare benefit cuts have eroded Medicare protection for beneficiaries. Per capita health care expenditures are estimated to equal 15 percent of the average income of older Americans in 1984, the same as in 1966, before Medicare was fully implemented. Under current legislation, by 1989 this percentage will be 18 percent.^{5/}

Medicare beneficiaries pay more for doctors' services than for any other health care category. The average out-of-pocket cost to the elderly in 1984 was \$461 for doctors' services compared to \$216 for hospitalization.^{6/}

Pressure on government budgets and the pocketbooks of the elderly will grow as long as health care inflation continues rising. Inflation of physician services has been 45 percent higher than general inflation minus medical care since 1965 when Medicare began (see Chart 1). The differences in the inflation rates widened significantly in the 1980-83 period.^{7/}

AARP estimates that doctors are responsible for 80 percent of total health care spending, either directly or indirectly through ordering hospitalization, laboratory tests, treatments and prescriptions.^{8/} Doctors have tremendous responsibility for the delivery of high quality health care, and they have been more than adequately

compensated with respect and income. An average doctor's annual income after expenses soared to \$106,300 in 1983. This annual income is much higher than the annual salary of a Congressman and many times higher than the average earnings of workers. It is ten times the median annual income of the male elderly and nearly twenty times the median annual income of the female elderly (see Chart 2).

Can we control doctors' fees and still maintain the quality of care? Drawing on numerous research findings, one commentator has concluded that "1) for a given level of health outcome, the Nation is not using the most economically efficient combination of inputs; and 2) present means of public and private financing of health care give powerful incentives for such an inefficient combination of inputs."^{9/}

Medicare Concessions to Doctors in 1965

The principal doctors' lobby, the American Medical Association (AMA), opposed the enactment of health insurance for the elderly. Instead of Medicare, the AMA supported a welfare program for the elderly. As part of their stance, the doctors' lobby charged that the government would attempt to control their fees and income with Medicare.

As a compromise, Congress agreed to disturb as little as possible the fee-for-service reimbursement of doctors. Congress agreed to pay physicians what they asked to be paid so long as that amount was not higher than they usually charged, or unreasonable in relation to what other physicians in the area were billing for the same services.^{10/}

One final concession to the doctors was voluntary assignment. "Assignment" refers to a doctor's agreement to accept the Medicare-determined reasonable charge as

full payment.*/ Medicare required mandatory assignment for hospitals, hospital-based doctors, and joint Medicare-Medicaid claims. However, it permitted private doctors to charge Medicare patients more than the Medicare-determined reasonable charge on a case-by-case basis.

Thanks to these legislative concessions, doctors became major financial beneficiaries of Medicare. Not only did the elderly now have the financial means to pay doctors for health care; doctors were also able to set their own fee schedules. Even when Medicare reduced a high fee, doctors could still collect the difference from the patient, and that high fee helped push up the "reasonable fee" level in future years.

The Consequences

By 1972 Congress recognized that the reimbursement policy was inherently inflationary. In an amendment to the Act, it then limited increases in prevailing charge levels to the extent justified by an economic index reflecting changes in operating expenses and earnings levels of all workers.

Despite Congressional intent to hold down medical inflation to beneficiaries and the government, an Urban Institute study has concluded that "the economic index had the effect of slightly reducing Medicare (as well as Medicaid) outlays; at the same time overall beneficiary liability rose (emphasis supplied)."¹¹/ Physician fees and Medicare reasonable charges, moreover, have continued to increase at rates greater than justified by the economic index (See Chart 3). This is because the economic index held down

*/ Medicare beneficiaries are responsible for 20 percent of the Medicare-determined reasonable charge after satisfying an annual deductible which is currently \$75. In addition, beneficiaries pay premiums which will total \$186 in 1985.

charges of doctors whose fees were on the high end but did not slow down increases in charges of doctors who had not yet reached the reasonable charge "threshold."

Beneficiary liability has actually increased on the claims for which doctors do not accept assignment. Excluding Medicare/Medicaid claims, for which assignment is mandatory, private doctors accepted assignment voluntarily for only 39 percent of claims in 1980.^{12/} Physician fees now are nearly 25 percent above the Medicare-determined reasonable charge (see Chart 4). The beneficiary must pay this difference in non-assigned cases.

The AMA Non-Solution

In its 1984 Report, the AMA Board of Trustees called for higher taxes and increased out-of-pocket charges to beneficiaries as well as income testing of benefits. It opposed the use of cost control on doctors' fees.^{13/} The AMA's president said recently that the percentage of Gross National Product (GNP) devoted to health care in the United States "is comparable to the percentage of GNP in many other countries in the western world. The alternative in other countries, however, to control this, has been to markedly ration needed services."^{14/}

This is not true. Health care spending in the United States is more than health care spending in France, Germany and Canada. These are foreign countries where doctors are reimbursed on a fee-for-service basis similar to doctors in the United States. The only difference is that doctors cannot set their own fees but must negotiate them. Health care spending as a percent of GNP in France and Germany is equal to or less than such spending in the United States, even though the percent of the

Table 1. Health Care Expenditures and Elderly Population, Selected Countries, 1980

	<u>Health Care Expenditures as Percent of GNP</u>	<u>Percent of Population Age 65 and Over</u>
United States		9.5 10.7
Canada	7.4	8.9
France	9.1	13.7
Germany	9.5	15.0

Sources: International Studies and Activities Staff, Social Security Administration and Demographic Indicators of Countries: Estimates and Projections as Assessed in 1980, Department of International Economic and Social Affairs, United Nations, 1982.

population age 65 and over is much higher. Health care spending in Canada is nearly 25 percent lower than in the U.S. The lower Canadian spending is very striking, since economic, demographic and cultural conditions are very similar.

The AMA understandably wants to preserve the current financially advantageous system for doctors. To maintain the current system, however, will result in escalating costs for the taxpayer and unaffordable health care for the elderly. The American people don't have to accept this in light of the lack of competition in the market for doctors' services.

Competition

Doctors praise the free enterprise system, but defend their own ability to set fees in disregard of economic forces. If a truly competitive market existed for doctors' services, the cost of Medicare would be lower.

According to a recent Senate Information Paper, ". . . Medicare should be able to achieve substantial discounts below its present rates [based] . . . on considerations

of its market share, physician oversupply, and demonstrations of this approach in the private sector."^{15/}

Medicare reimbursements account for 18 percent of physicians' income. "Certainly a private business with such market power would be unlikely to let its suppliers dictate prices."^{16/} If assignment were mandatory, few physicians could afford to refuse to treat Medicare patients.

Despite a 40 percent increase in the supply of doctors in the 1970s and a projected 30 percent increase in the 1980s, doctor's fee increases have not moderated or stabilized. Doctors have reduced their workload and expanded their net practice incomes even during the 1982 recession year.^{17/} They countered price controls during the early seventies by "increasing the volume of services provided each patient and changing to a more complex service mix."^{18/}

Doctors are beginning to feel competitive pressure from the doctor oversupply as well as new alternatives to the fee for service health care systems, including health maintenance organizations. Doctors at the AMA convention last June complained about the effect of this increased competition on their incomes.^{19/}

The Medicare Patient

The Medicare patient is really at the mercy of his doctor. The AMA's public policy is to encourage doctors on a case by case basis to accept assignment for those beneficiaries for whom additional payment would be a hardship.^{20/} Such a policy severely strains the patient/doctor relationship. Some of our members cannot afford unassigned fees but cannot find a doctor who will accept assignment. One member

writes ". . . I do not have a personal doctor. The reason is that I have not found any such person who will accept assignment at all and I cannot afford to pay him myself."

The National Committee recently asked members to question their doctors about their fee and assignment policy. Some members did not ask their doctors out of fear. One member from Bristol, Tennessee wrote:

I did not call my doctor because I am afraid to. I am disabled and have a lot of medical bills. The doctors here stick together like glue. They will not accept a new patient, if that person has been under another's care. They resent Medicare and wish it would go away, at the same time pricing it out of business.

Another member from Louisville, Kentucky wrote:

I would like very much to help you on this questionnaire but feel sure all doctors are going to resent these questions. I have a heart condition and feel I cannot take the chance of my doctor telling me he doesn't want me as a patient any longer. This has happened to two of my friends when they questioned their doctor about an appointment and a bill. Sorry.^{21/}

Some people argue that patient cost sharing discourages patients from seeking unnecessary medical care. Whether or not this is true, in 1983 Medicare beneficiaries were asked to pay 60.9 percent of their doctors' bills,^{22/} surely an amount that is much more than necessary to discourage patients from seeking unnecessary medical care. Furthermore, there is no evidence that beneficiaries are abusing the Medicare insurance program. According to an information paper prepared for the Senate Special Committee on Aging, "Use of physician services for all ages and the over-65 population has changed very little for per capita physician visits since 1970, and has actually declined since 1972."^{23/}

In any event, patients probably rely more on a doctor's advice about what medical care is necessary than on its cost. This is why people buy health insurance and

why Congress created the Medicare health insurance program in the first place. Any increased cost sharing will only deny health care to the sickest and poorest of the elderly.

Quality of Care

Doctors point to the high quality of health care in the United States as justification for the current health care system. Some aspects of the current system, however, detract from the quality of care. "One of the major critiques of Medicare's reimbursements is that they are not neutral with respect to physician's decisions about appropriate medical practice,"^{24/} reports the Senate Special Committee on Aging. To the contrary, Medicare encourages expensive health care that is often unnecessary.

Incentives in the current reimbursement system give doctors financial motivation to favor inpatient hospital care rather than outpatient care, and surgery rather than non surgical treatment. Surgery and hospital-based care produce higher revenues per hour for most doctors.^{25/} To the extent that a patient is hospitalized when he shouldn't be or, worse, operated on when that is not necessary, the quality of care becomes less than optimal and the cost to Medicare and the beneficiary is greater than necessary.

Most elderly patients should have a regular doctor who provides the majority of a patient's care. However, the proportion of such general care doctors has been declining. Medicare and other insurance companies reimburse specialists at higher rates, thus producing incomes for specialists that are 60 percent higher than incomes of primary care doctors. Exacerbating this, the incomes of specialists are expanding at significantly higher rates.^{26/} "There is some evidence that the specialist/generalist

differential [in Medicare reimbursement rates] may be higher than warranted by differences in quality and intensity of care provided. . .²⁷/ a Congressional background paper claims.

Finally, high quality health care is of no benefit to Medicare beneficiaries if it is priced beyond their reach. Rarely-used voluntary assignment and rapidly increasing premiums, deductibles and copayments means that many beneficiaries cannot get the health care they need.

Controlling doctors' fees only for Medicare beneficiaries, however, eventually could lead to Medicare beneficiaries receiving an inferior level of care compared to the rest of the population. Some proponents of change argue that unless cost controls similar to Medicare controls are extended either legislatively or through common practice to all payers of health care, doctors (and hospitals) will naturally give more attention to their higher paying customers.

Conclusion

Reform of the Medicare fee-for-service reimbursement system for doctors is imminent. Fee-for-service medicine can be maintained, but current costs charged to Medicare and the beneficiary are unreasonable.

Medicare should establish prospective fee schedules that provide doctors reasonable reimbursement for their valuable service. Incomes of doctors who charged excessive fees in the past will likely suffer in the short term as these doctors adjust to more reasonable fee levels. However, doctors would only be one of many groups of workers forced to take pay cuts recently. Increases in fees in future years should be limited to the economic index.

As Medicare fees are rationalized, doctors cannot be permitted to soak the beneficiary for the difference. Mandatory assignment is necessary. Finally, Congress should continue to encourage competitive alternatives, such as HMOs, which can provide increased coverage at less cost.

FOOTNOTES

- 1/ Conversation with Office of the Actuary, Health Care Financing Administration.
- 2/ 1984 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, p. 12.
- 3/ 1984 Annual Report of the Board of Trustees of the Supplementary Medical Insurance Trust Fund, p. 22 and Budget of the United States Government FY1985, p. 9-61.
- 4/ "Medicare and the Health Care Costs of Older Americans: The Extended Effects of Cost Sharing." An information paper prepared for use by the Special Committee on Aging, United States Senate, April 1984, p. 14-15. (Hereafter referred to as "Medicare and Health Care Costs.")
- 5/ "Future Deficit Reduction: Impact on Aged and Poor," A background paper presented by Edward R. Roybal, Chairman, Select Committee on Aging, U.S. House of Representatives, September 1984, p. 17.
- 6/ Select Committee on Aging, U.S. House of Representatives.
- 7/ "Medicare: Paying the Physicians — History, Issues, and Options," An information paper prepared for use by the Special Committee on Aging, United States Senate, March 1984, p. 8. (Hereafter referred to as "Medicare: Paying the Physicians.")
- 8/ "Physician Fees Outpace Inflation." AARP Legislative Report, May-July 1984, p. 1.
- 9/ Ronald J. Vogel, "An Analysis of Structural Incentives in the Arizona Health Care Cost-Containment System," Health Care Financing Review, Volume 5, Number 4, p. 13.
- 10/ "Medicare: Paying the Physicians," p. 3.
- 11/ "Background Data on Physician Reimbursement Under Medicare," Prepared by the staffs for the use of the Committee on Finance, United States Senate, and the Committee on Ways and Means and Energy and Commerce, U.S. House of Representatives, October 1983, p. 39. (Hereafter referred to as "Background Data on Physician Reimbursement.")
- 12/ "Medicare: Paying the Physician," p. 30.
- 13/ "Report on the Medicare Program," AMA Board of Trustees, June 1984 p. 12, 15-20.
- 14/ "Interview with AMA President Joseph F. Boyle," USA Today, July 26, 1984, p. 9A.

- 15/ "Medicare: Paying the Physician," p. 26.
- 16/ Ibid.
- 17/ Ibid., p. 12.
- 18/ "Background Data on Physician Reimbursement," p. 86-7.
- 19/ "Doctors in Straits, AMA Told," The Washington Post, June 18, 1984, p. A3.
- 20/ "Report on the Medicare Program," AMA Board of Trustees, June 1984 p. 21.
- 21/ Letters to National Committee to Preserve Social Security and Medicare, available on request, names of writers are confidential.
- 22/ "Physician Fees Outpace Inflation," AARP Legislative Report, May-July 1984, p. 3.
- 23/ "Medicare and Health Care Costs," p. 21.
- 24/ "Medicare: Paying the Physician," p. 21.
- 25/ Ibid., p. 21-22.
- 26/ Ibid., p. 12.
- 27/ "Background Data on Physician Reimbursement," p. 95.

Chart 1. General Inflation Compared to Doctors' Fee Inflation, 1965-1984

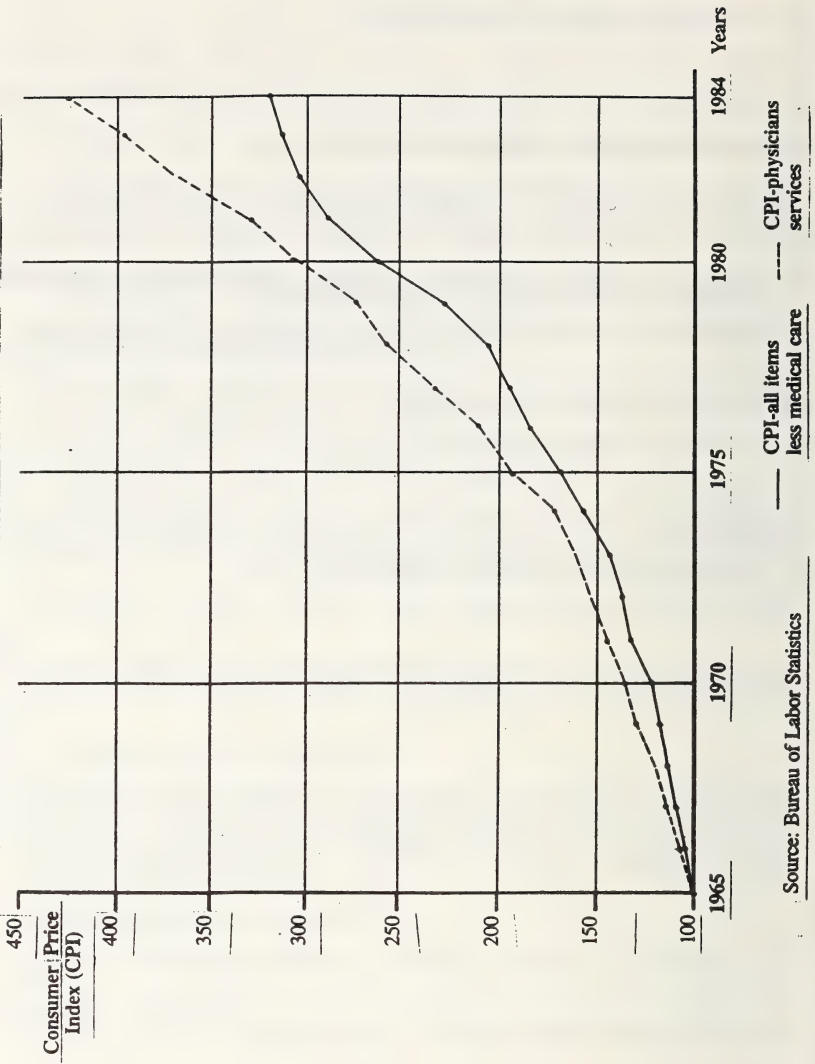
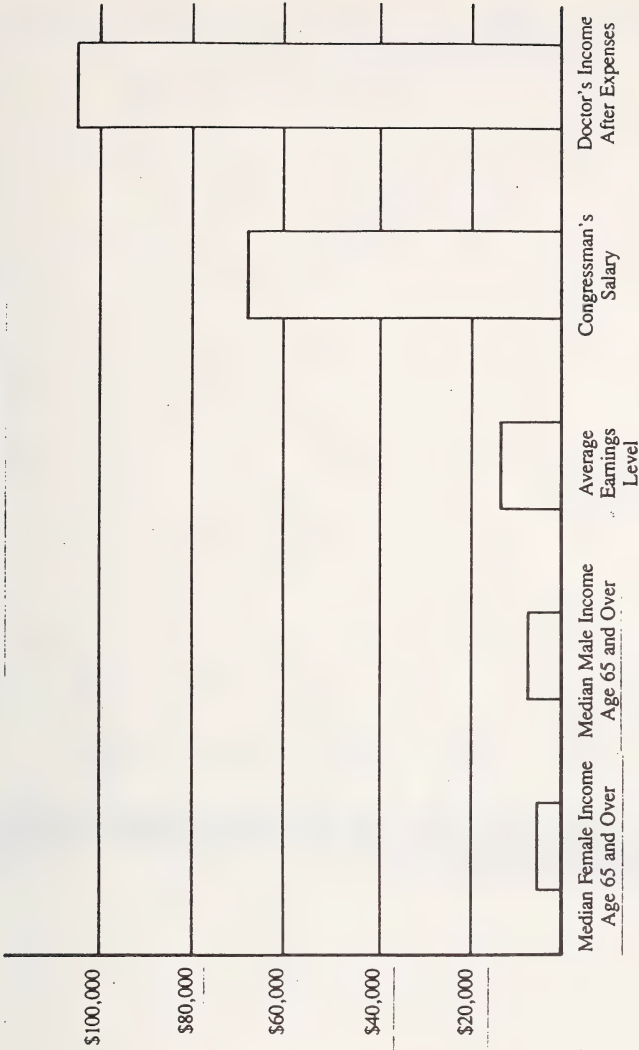
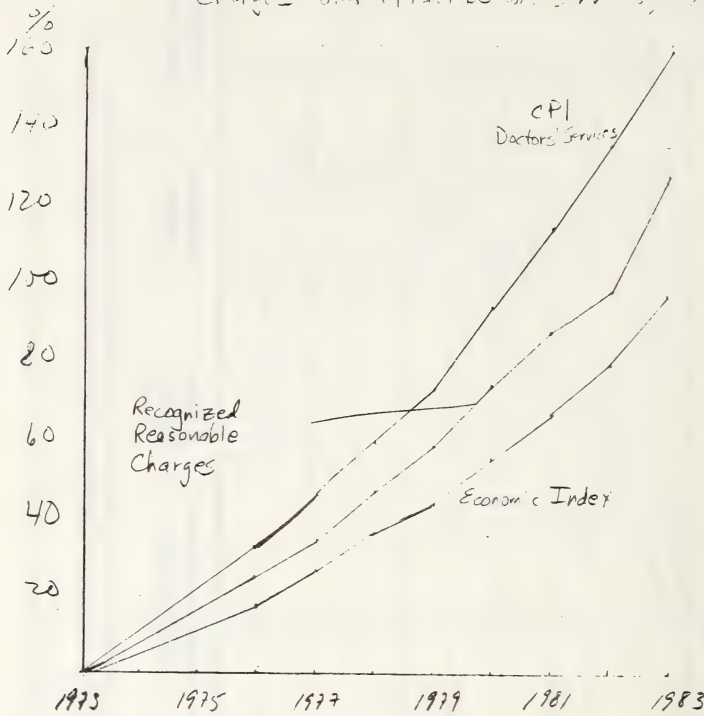


Chart 2. Income Comparisons, 1983



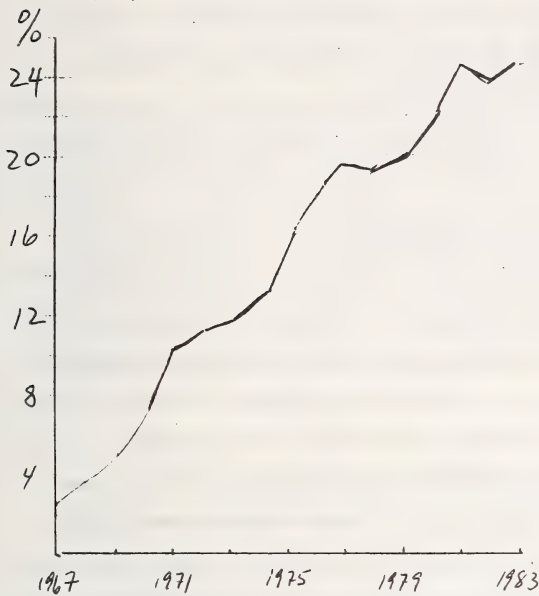
Sources: Census Bureau for Median Income, Age 65 and Over; Social Security Administration for Average Earnings Level; U.S. Congress for Congressman's Salary; and American Medical Association for Doctor's Income

Chart 3- Increase in Economic Index, Recognized Reasonable Charges and CPI for Doctors' Services, 1972-1983.



Source: 1984 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, p. 35, 38 and Background Data on Physician Reimbursement Under Medicare, p. 11.

Chart 4. Medicare Reductions of Physician Fees to the Aged, 1967 to 1983



Source: 1984 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, p. 35, 38.

Pathology Practice Association

Thank you, Mr. Chairman, for allowing the Pathology Practice Association (PPA) to submit testimony for the record in connection with a hearing held April 26 on Physician Payment Under Medicare.

The PPA is a national, non-profit organization comprised of pathologists practicing in hospitals and independent laboratories throughout the country. It was formed five years ago to advance a better public understanding of the practice of pathology. It is the PPA's philosophy that an ongoing education program aimed at government policy makers and the public at large will foster a clearer understanding of how pathologists, particularly those in private practice, contribute to health care and result in policy decisions on federal health care expenditures that will better service patients.

The Pathology Practice Association understands and appreciates the difficult decisions facing the subcommittee and the Congress. There is indeed a compelling need to find federal savings to reduce the general fund deficit, while at the same time there is an inherent responsibility to ensure that beneficiaries of our federal health care system are guaranteed access to services of a quality that they deserve and have been promised.

Mr. Chairman, we would like to urge the subcommittee to make a closer examination of the structure of the Medicare program in relation to the general fund. By and large, the federal Medicare program does not contribute to the general fund deficit. The Hospital Insurance Trust Fund is self-sustaining and 22.3 percent of the Supplemental Medicare Insurance Program (SMIP) results from premiums paid by beneficiaries. Moreover, we

would like to draw your attention to the most recent report of the Medicare Board of Trustees. That report, issued last month, projected that the HI Trust Fund will not run out of money until 1998, seven years later than previously anticipated. The SMI program was reported to be actuarially sound.

In their report, the trustees recognized that the stabilization of the general economy, together with the confluence of events in both the private and federal sectors, have brought a good measure of financial stability to Medicare.

It is our judgment that these encouraging projections demonstrate that neither new sources of financing nor program cutbacks are immediately necessary. Congress has the time now to consider more carefully the appropriateness of changes already made in the overall Medicare program to ensure its long-term financial viability.

Administration Budget Reduction Proposals

The Administration has offered two major proposals for Medicare savings that directly impact pathologists: an extension of the current physician fee freeze and the Medicare participating agreement program; and a freeze on charges for diagnostic testing that are now subject to a fee schedule. The PPA opposes both of these proposals.

An extension of the physician fee freeze would perpetuate the unfair burden doctors are being forced to bear in the name of deficit reduction. No other profession or any other section of the economy is being required to freeze their charges. Last year the Deficit Reduction Act eliminated the July 1 increase in physician prevailing rates; it delayed the increase to Oct. 1, 1985. The Administration proposal would deny prevailing rate increases for another year for all physicians.

This freeze extension could have a variety of deleterious effects. It would discourage physicians from accepting Medicare assignment and similarly could discourage physicians from caring for Medicare beneficiaries.

In a more specific sense, the Part B freeze continues to place an unfair burden on hospital-based physicians, particularly pathologists whose Medicare reimbursement in the past had been tied to combined billing for charges. These arrangements provided that billing for clinical and anatomic laboratory services be combined and that payment be made on a percentage. The arrangements worked well over the years. There appeared to be no reason to adjust upward prevailing charge levels for anatomic services since much of the pathologists' income was derived from clinical laboratory services.

The Tax Equity and Fiscal Responsibility Act enacted in the summer of 1982 changed all that. Clinical pathology, by and large, was classified as Part A reimbursable, combined billing was eliminated and pathologists were forced to bill directly for their anatomic Part B services. Carriers were required to construct new anatomic prevailing rates to accommodate the direct billing requirement. As carriers began to compile this data in 1983, the Deficit Reduction Act was enacted and physician fees were frozen. This then forced carriers to go back five to ten years in some cases to find reliable charge data. As a consequence, rates were set in many areas of the country far below what could ever be considered realistic and equitable.

The PPA strongly urges the subcommittee to seek concurrence on appropriate legislative language that would require the Health Care Financing Administration (HCFA) to instruct its carriers to recalculate anatomic prevailing charges based on the most recent and realistic charge data — data that is available from FY 83. If such language is adopted, more pathologists will be willing to accept Medicare assignment and charges now being borne by beneficiaries would drop dramatically.

The Pathology Practice Association also opposes the Administration proposal to freeze fees paid for diagnostic laboratory services currently under a fee schedule. The Deficit Reduction Act established a fee schedule for diagnostic testing and required assignment for hospital and independent laboratories. The schedule was based on 60 percent of prevailing charges and provided that the fees would be increased each year by the Cost of Living Index. The Administration's freeze provision breaches a commitment made by the Congress for adequate reimbursement to ensure high quality care.

MAJOR MEDICARE PART B REFORM

The PPA has additional concerns about the application of the two most widely touted major physician Part B reform measures now being studied by HCFA and the Office of Technology Assessment. These measures include an extension of DRGs to cover physician services and fixed fee schedules.

Evaluation — DRGs Applied to Physician Services

Our association is concerned about the following elements.

- **Lack of Information and Experience:** To our knowledge, there are no comprehensive data available on the applicability of extending DRGs to physicians, and only one study has attempted to test and evaluate the concept of reimbursing inpatient medical care on a per case basis. That study was conducted nine years ago by Pennsylvania Blue Shield and involved a number of physicians who agreed to accept reimbursement on a per case basis at any one of nine participating hospitals. No other study, to our knowledge, has been conducted since then. Moreover, HCFA is not now conducting any demonstration project on the feasibility of including physicians in the DRG payment mechanism. We would urge Congress and the Administration to move

cautiously on a physician DRG approach to reimbursement and we would urge the development first of one or more demonstration projects to determine: 1) the extent of federal cost savings, if any, and the impact of the inpatient payment scheme on outpatient services; 2) the impact on the quality of patient care; 3) the impact on the availability of services and technology; 4) the impact on hospitals and other non-physician providers such as skilled nursing facilities, psychiatric facilities, home health care, etc.; 5) and the extent of acceptance by various physician specialties.

- **Physician DRGs Could Have a Deleterious Effect on the Quality and Cost of Care:** Reimbursing physicians a predetermined amount for the treatment of patients would create disincentives for them to spend significant and necessary amounts of time on patient care. The PPA concurs with a statement on the potentially adverse impact on the quality of care as presented in a position paper on DRGs prepared last year by the American Society of Internal Medicine. The paper stated in part:

This type of system also creates economic incentives for physicians to skimp on care. While most physicians would continue to provide the best quality care possible given the limited resources available, a prospectively determined "cap" on reimbursement for a given diagnosis may force physicians to discharge patients earlier than is optimal, decrease necessary visits, and/or make decisions not to use costly — but more effective — forms of treatment. This is particularly likely for older and sicker patients for whom the DRG payment is likely to be lower than the actual resources required.

Beyond this and in a more specific sense, it is likely that primary care physicians would decrease their use of physician consultants and attendant ancillary services that are critical for comprehensive patient care. This could have significant medical consequences for the beneficiaries.

The PPA also believes that any DRG payment mechanism applied to physicians should recognize that medical technology is a necessary component of comprehensive, quality patient care. A DRG system must have the flexibility to provide for necessary advancements in medical technology and procedures.

- **Pathologists and Other Hospital-Based Physicians Should be Separated From Any Overall DRG Payment System for Physicians:** To the extent that providers control utilization of services, hospital and physician cost containment concerns have and should rightfully center on those providers who initiate care. Medicare Part A (hospital costs), according to data compiled by the Senate Committee on Aging, is the second largest federal program after Social Security. The hospital Part A expenditures are projected to exceed \$50 billion by 1985. Three quarters of the Part B costs are for direct doctor services, the remaining one-fourth are for services ordered by physicians and performed mostly by physician consultants, including pathologists, radiologists, cardiologists, etc. Under current Medicare reimbursement mechanisms, all physicians, except those who are hospital-based, provide whatever services they deem necessary to treat the patient properly and are paid based on usual, customary and reasonable payment rates. Hospital-based physicians, including pathologists, act as consultants to these primary care clinicians and perform work for patients as ordered. With rare exception, pathologists do not initiate tests or control to any degree of frequency the application of laboratory technology. Therefore, DRG cost containment mechanism should be applied differently to those physicians who do not initiate care, such as hospital-based pathologists.

● **DRG Payments Should be Paid Directly to Those Who Provide the Service and Not Through the Hospital or the Primary Care Physician:**

Any proposal which requires that DRG reimbursement be made to and allocated by the hospital or the primary care physician compromises the individual physician's traditional role as an advocate for the patient and disrupts the implied contract between the doctor and the patient. Patients already are feeling the effects of changes in hospital reimbursement under prospective payment. Some hospitals are retaining Part A payment for pathology services, and consequently in those hospitals these services may not be provided at the same level of intensity. When hospital and physician reimbursement is separated, as under the current reimbursement system, patient care is safeguarded because physicians are not dependent upon the hospital or other group providers for payment of services. A DRG system that pays hospitals a single sum for all medical care would dramatically alter the doctor/patient relationship because both parties would stand to benefit financially from minimizing care and services. A DRG system that pays consultants through the primary care physician would have the effect of decreasing use of those consultants who are so critical to comprehensive patient care. The only way to preserve quality care is to ensure that payment for services is made directly to those who provide the services.

Evaluation -- Negotiated Fixed Fee Schedules for Physicians

The Administration is considering proposals to establish fixed fee schedules for physicians. The PPA has the following concerns over a fixed fee schedule:

- **Any Fixed Fee Schedule Payment System Must Be Constructed Carefully and Equitably.** The major consideration in the design of a fixed fee schedule is the initial level at which fees are established. Some government officials have suggested that the total costs generated by any fee schedule should not exceed that which would have been paid under the current system. This would mean, however, that some physicians would have to accept a reduction in recognized fees. The PPA believes that any fee schedule should be set at the upper ranges of current distribution and be based on a relative value scale, that a mechanism be established for equitable fee schedule adjustments, and, moreover, that accurate and realistic prevailing rates must first be set by the carriers.
- **Any Fixed Fee Schedule Must Preserve the Concept of Direct Payment.** As stated in the section on physician DRGs, any reimbursement mechanism that does not provide direct payment to the physician performing the service compromises the quality of patient care and destroys the role of the physician as patient advocate. A physician fee schedule that allocates a single sum to hospitals or any other group provider would compromise the doctor/patient relationship because both parties would benefit financially from minimizing care and services. And a fee schedule that pays consultants through the hospital or primary care physician would have the effect of decreasing use of those consultants who are so critical to comprehensive patient care.
- **Mandatory Assignment Attached to a Fixed Fee Schedule Might be Supported by Pathologists Under Certain Conditions.** Recognizing the constraints on the Medicare program, pathologists could support

mandatory assignment of Medicare payment, if three conditions were met: 1) that HCFA conduct a study in conjunction with organized medicine to determine accurate and fair prevailing rates nationwide with emphasis given to urban and rural wage differentials and other factors; 2) that HCFA abandon individual physician profiles, which tend to produce inequities; and 3) that Congress enact technical correcting language to current DRG legislation to provide that all Part A professional services rendered by pathologists be passed through to the pathologists and not retained by the hospital.

● **A Fee Schedule Must Recognize Part B Payment for Autopsies.**

Autopsies serve as one of the most important forms of quality control in patient care, ensuring accuracy of diagnoses. They are also a far more accurate tool for measuring appropriate medical utilization than the expensive Peer Review Organizations. Autopsies also play a critical role in medical research by evaluating the accuracy of new forms of medical treatment and diagnostic techniques. Yet, this long-standing professional service is not recognized as such under current Medicare reimbursement provisions. The PPA believes that if a fixed fee schedule is established, rates commensurate with the time and skill required to perform an autopsy must be established and paid under Part B, or the Part A reimbursement now given to the hospital must be passed through to the pathologist.





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